

Experience of Indonesian medical students of ethical issues during their clinical clerkship in a rural setting

Raditya Bagas Wicaksono^{1*}, Miko Ferine¹, Diyah Woro Dwi Lestari¹, Arfi Nurul Hidayah¹, Amalia Muhaimin²

1.Lecturer, Department of Bioethics and Humanities, Faculty of Medicine, Universitas Jenderal Soedirman, Purwokerto, Indonesia.

2.Lecturer, Department of Bioethics and Humanities, Faculty of Medicine, Universitas Jenderal Soedirman, Purwokerto, Indonesia; Researcher, Department of Ethics, Law, and Humanities, Amsterdam University Medical Centres, University of Amsterdam, The Netherlands.

Abstract

Although ethics is an essential part of medical education, little attention has been paid to ethics education during the clerkship phase, where medical students observe how physicians make decisions regarding various ethical problems. Specific nuances and cultural contexts such as working in a rural setting can determine ethical issues raised. This phenomenology study aimed to explore ethical issues experienced by Indonesian students during clinical clerkship in a rural setting. In-depth interviews were used to explore students' experiences. Participants were ten students, selected on gender and clerkship year variations. Data saturation was reached after eight interviews, followed by two additional interviews. Thematic analysis was used in this study, and trustworthiness was ensured through data and investigator triangulation, member checking, and audit trail.

Three main themes found in this study were limited facilities and resources, healthcare financing and consent issues, as well as unprofessional behavior of healthcare providers. Many ethical issues related to substandard care were associated to limited resources and complexities within the healthcare system in the rural setting. Early exposure to recurrent ethical problems in healthcare can help students prepare for their future career as a physician in a rural setting.

Keywords: Ethical issue; Medical students; Clinical clerkship; Indonesia.

*Corresponding Author

Raditya Bagas Wicaksono

Address: Jalan, Dr. Gumbreg, Nomor 1, Mersi Purwokerto, 53112, Banyumas, Jawa, Tengah, Indonesia.

Tel: (+62) 85 74 77 68 695

Email: r.bagas.wicaksono@unsoed.ac.id

Received: 29 Aug 2020

Accepted: 1 Jun 2021

Published: 13 Jul 2021

Citation to this article:

Wicaksono RB, Ferine M, Lestari DWD, Hidayah AN, Muhaimin A. Experience of Indonesian medical students of ethical issues during their clinical clerkship in a rural setting. *J Med Ethics Hist Med.* 2021; 14: 6.

Introduction

Ethics has been considered an essential part of medical education in developed countries (1,2). This concern is currently the case in developing countries, including Indonesia, where competencies in ethics are stated clearly in the Standar Kompetensi Dokter Indonesia (SKDI), Competency Standards of Medical Doctors. However, ethics education was overlooked during clinical clerkship phase, where medical students may encounter various ethical problems and authentic learning experiences throughout their clinical training (3,4). Teachers and healthcare providers may have different perspectives and standards when managing ethical issues, causing challenges and difficulties for students in understanding and mastering skills in ethics (5). Moreover, when confronting ethical issues, medical students often feel hopeless and powerless, perceiving themselves as the lowest in the hierarchy (6).

Throughout the world, ethical issues faced by medical students during their clerkship phase vary from profession-related issues (e.g., inappropriate physician behavior, physician-patient and physician-peer relationship) to issues surrounding end-of-life care, privacy and confidentiality, and informed consent (7–11). Nevertheless, issues related to financing difficulties and justice emerged in some studies (7,8). Other studies reported issues regarding uncertainty of students' roles and responsibilities in healthcare, leading to dissatisfaction with how they manage ethical concerns during the clerkship (11–13).

Different healthcare settings with particular nuances and cultural contexts in each area can determine the type of possible ethical issues (14). This nuance includes remote and rural areas where human resources and healthcare facilities are scarce and access to healthcare is limited, making it challenging for patients (15,16). Not many studies focused on ethical issues reported by the medical students in the areas with the scarcity of healthcare resources in Indonesia. Therefore, this study aimed to explore ethical issues encountered by the medical students working in a rural setting in Indonesia.

Methods

Study Design, Participants, and Setting

This phenomenology study used purposive sampling and collected data through in-depth interviews (17). Medical students involved in this study had their clinical clerkship in Banyumas, Central Java, Indonesia. Participants eligible for this study were medical students who had attended six months of clinical clerkship. Medical students in Indonesia must undergo two years of clinical clerkship; hence, participants were categorized into the first year and final year. As a part of data triangulation, a wide variety of students were chosen considering gender and clerkship year variations. Participants were added until data saturation was reached. Data saturation has been an important part of the qualitative research methodology where new data tend to be redundant (18). After eight interviews, data saturation stage was reached, and two additional interviews were conducted to ensure that no new data or code would appear.

Data Collection

Data was collected in September-October 2019, and participants were informed about the study goals. Interviews were conducted by RBW, DL, and MF in Bahasa Indonesia based on the following questions:

- During your clinical clerkship, have you ever encountered any ethical issue?
- Can you tell us the most notable cases you have experienced?
- Are there any other cases that you still remember?

Additional questions were asked according to the participants' responses to these base questions. The duration of interviews ranged from 32 minutes to 76 minutes (average of 45 minutes). Due to familiarity of participants with the interviewers, establishing relationship and trust was straightforward, which was required to ensure the honesty of participants' answers (19, 20).

Data Analysis

Thematic analysis was employed to identify, analyze, and report the patterns and themes that emerged from the data (21). Interviews were transcribed verbatim by two members of the research team (RBW and DL). Transcriptions of the interviews were initially coded and analyzed by RBW and MF, and further discussed with all investigators to review the codes. Two team members, ANH and AM, did not conduct the interviews and were involved in data analysis, to enhance study's credibility. Involving different investigators from various backgrounds –notably medical

physicians, medical educators, and psychologists – is a part of investigator triangulation to enhance study's credibility (21,22). All research team members discussed all findings and codes to have a general understanding of the data. After the refinement and removal of the overlapping codes, the team classified the codes into eight categories and three themes. Discussions were done iteratively until consensus and data saturation were reached.

Study Trustworthiness

The trustworthiness of this study was ensured through several validation strategies such as data and investigator triangulation, member checking, and audit trail. The credibility of the study was maintained through the member checking process by sending data, interpretations of transcripts, and conclusions to the participants. This process was done to ensure their meanings and perspectives were correctly translated and represented (23). Some of the participants suggested minor adjustments; therefore, adjustments were made accordingly. All participants responded well and agreed with interviews' translation and interpretation. The first author kept the records of raw data, transcripts, and reflexive journals to ensure a clear audit trail and increase credibility (21).

Ethical and Research Approval

This study was approved by the Health Research Ethics Committee of the Faculty of Medicine, Universitas Jenderal Soedirman (application no. 3533/UN23.07.5.1/PP.1/2019). In accordance with the Declaration of Helsinki, permission for audio recording and

field-note taking was obtained in written consents before the interviews. The interviewer explained that all data would be kept anonymized and unidentifiable to ensure the privacy and confidentiality of participants, patients, physicians, and other healthcare providers

Result

Ten students were interviewed with a balanced distribution of gender. Participant's characteristics are presented in table 1. In this study, twenty-eight codes were found, classified into eight categories: substandard care, lack of privacy, students' exploitation and less prioritized education, financial difficulties, issues of consent, fraud, harassment, and inadequate inter-professional collaboration. All categories were then classified into three themes: (i) limited facilities and resources, (ii) healthcare financing and issues of consent,

and (iii) unprofessional behavior of healthcare providers.

Table 1- Participants' characteristics

Participants	Gender	Clinical Clerkship's Year	Interview Duration (minutes)
1	Male	First-year	58:23
2	Female	Final year	41:09
3	Female	Final year	47:47
4	Female	Final year	38:07
5	Male	Final year	32:13
6	Female	First-year	35:57
7	Male	First-year	47:10
8	Male	Final year	38:13
9	Female	Final year	38:22
10	Male	First-year	76:46

Table 2 delivers an outline of ethical issues experienced by students during clinical clerkship in a rural setting. The classification of ethical issues was arranged based on their relevancy with certain areas in bioethics, healthcare, and education.

Table 2- Ethical issues observed by students during clinical clerkship

Codes	Categories	Themes
Under time consultation Physician interrupting patient Overload emergency department Slow response of the supervisor Determining the patient's medical plan without further examination Rushed examination Hasty operation	Substandard care	Limited facilities and resources
Discussing patient's diagnosis in front of other patients Examining more than one patient in a room	Lack of privacy	
Unnecessary task which was unrelated to education Excessive workload Patient care relied on student's existence Students did procedures without supervision Limited time for clinical coaching	Students' exploitation and less prioritized education	Healthcare financing and issues of consent
Limited medication choice in national health insurance formularies Inadequate therapy due to limited insurance coverage Patient's accommodation not covered by insurance	Financial difficulties	
Delayed life-saving procedure Directive informed consent	Issues of consent	Unprofessional behavior of healthcare providers
Falsifying patients' medical condition Making up CPR scenes Doctor brags to cover up futile operation	Fraud	
Verbal humiliation among healthcare providers Sexual harassment of medical students Bullying in the clinical clerkship	Harassment	Unprofessional behavior of healthcare providers
Nurse disobeying physician's order Physician refusing to consult a nutritionist for diet therapy	Inadequate inter-professional collaboration	

Limited Facilities and Resources

Participants in this study often shared cases of substandard care due to limited facilities and resources, which negatively affected the quality of care. A participant shared her experience witnessing a physician who has 100 to 150 patients a day. The physician requested the student to type the prescription long before the consultation started, to accelerate the patient flow.

“In one of the outpatient clinics, there were hundreds of patients every day. Before the patient came inside the examination room, the physician already prescribed the medications. This happens every day! So, the patient only met the physician for one or two minutes. I mean, just like that?” [Participant No. 3]

Other participants also observed limited contact time between the physician and the patients. In some cases, the physician did not respond to the patients' complaints regarding their health condition. Several examinations and medical procedures were done carelessly and in a rushed setting. Even when a surgical procedure was needed, the physician did not explain thoroughly to the patient. Hence, the patient's hopes and expectations while visiting the physician could not be fulfilled.

Limited healthcare resources led to other issues related to privacy and confidentiality. Some participants witnessed how patient's privacy was neglected, for instance, when a specialist simultaneously examined more than one patient in the outpatient clinic.

“Patients were called into the physician's

room, and they were sitting next to each other, in front of the specialist. All of this happened in less than 5 minutes. Patients came in, the physician checked the medical records for previous diagnosis and treatment, and the physician asked, “What's your name?” then, “All right, this is the prescription, go out,” without any proper examination.” [Participant No. 6]

She felt that this practice was inappropriate in any medical case, especially when patients have a severe condition or suffer from a terminal illness. Patients were also not allowed to ask any questions, let alone to make an informed decision. Other participants also witnessed a specialist instructing a patient to unbutton her shirt in the presence of other patients. Patients were mostly startled, but they hesitated to refuse the order.

Students also stated issues surrounding the training system in clinical clerkship. One prevalent issue was the exploitation of medical students. Students complained that their time was mostly used to help provide care to the patient while not receiving adequate supervision from their supervisors (medical specialists), especially when facing shortage of healthcare workers. A participant described those students often received instructions from nurses to perform tasks unrelated to medical training.

“Tasks without any relation to clinical knowledge are not supposed to be given. I disagree on this matter. For instance, we have to transport the patient from the emergency delivery room in the front part (of the hospital), to the neonatal ward way

back there... I think we should use our energy efficiently since we have many things to do...." [Participant No. 10]

The participant thought that tasks given to medical students should have clinical relevance not to cause unnecessary fatigue, affecting their work performance in the department.

Healthcare Financing and Issues of Consent

Ethical issues regarding substandard care also involved by the healthcare financial complexities or were caused by them. Participants observed difficulties and dilemmas faced by physicians when deciding on the treatment plan. Disparities were observed between treatment in the medical guidelines and the Jaminan Kesehatan Nasional, or JKN national health insurance formulary.

"Physicians often told us that the JKN formulary is inaccurate. But still, we follow the formulary... since most patients are JKN patients, so we have to follow the JKN rule to get the insurance claim... 'it's very limited, we can't give therapy based on the guideline'... these are complaints from physicians..." [Participant No. 8]

A participant observed a case of delayed treatment on an emergency patient due to issues of consent.

"The internist ordered emergency hemodialysis for him, but it was not performed. There was no guardian or family member who could sign the consent form. The emergency physician, internist, and hospital staff were all reluctant to perform the hemodialysis... As far as I know, there is

no need for consent for life-saving medical procedures. Why did the hospital refuse to do the hemodialysis?" [Participant No. 4]

The participant believed that informed consent was not needed in an emergency setting. Nevertheless, the hospital and medical team were doubtful to perform emergency hemodialysis in this case, as there was nobody available to give consent and funding guarantee.

Unprofessional Behavior of Healthcare Providers

The participants shared cases of unprofessional behavior from healthcare workers, including fraud and harassment. A participant, witnessed how a healthcare worker manipulated a patient's condition while reporting to the specialist on duty. The student knew the patient's real condition and was aware of the invalid data in medical reporting.

"She (the healthcare worker) didn't want to wait as it was rather a long observation to go. Usually, they report it (the patient's condition) as worsening. Just like now... She called the specialist, 'the patient is now vomiting.' In this patient's case, vomiting is a subjective emergency symptom that may become an indication for operation." [Participant No. 7]

The specialist eventually gave instructions for operation, which would be performed by a resident in the department. The patient was then transferred to the emergency operation room. According to the student, this was not the only case related to the manipulation of data. He encountered multiple similar cases while undergoing his clinical clerkship.

Another student, witnessed what he called a “fake” CardioPulmonary Resuscitation (CPR) since it was only done superficially or incompletely. He was annoyed and tried to make suggestions on how to perform a qualified CPR to the available nurse in the ward, which was ignored and thereby created one of the most memorable ethical issues for him.

Students sometimes became an object of harassment by the medical team, and a male student witnessed how his female colleagues were verbally harassed in the operation theatre.

“From what I saw by myself and what my friends experienced...It was more or less harassment, mostly done by (male) nurses... verbally, starting from ‘Have you ever done breast self-examination (SADARI)? Where did you do that? Come here, let me do that to you’...also physical (harassment) like... grabbing one’s shoulder and hip... even hugged from behind... sadly, sometimes, the physician also joins the conversation by asking simple questions like... ‘Do you have a boyfriend? What things have you done together?’” [Participant No. 5]

He thought that such behavior is unacceptable, especially in an academic setting. He felt upset to see the same practice repeatedly. Other unprofessional conduct occurred in collaboration between physicians and other healthcare workers. For instance, a student, reported a physician who deliberately discarded patient’s meal provided by the hospital nutrition unit because it was considered unhealthy. The patient was startled. The physician hesitated

to talk directly to the hospital nutritionist because he believed his dietary plan was better than that of the hospital. Another case of collaboration difficulty among healthcare providers was also shared by another student, who shared his experience regarding patient transfer from the emergency department to the clinical wards. He observed a delay in therapy due to the patient being referred and transferred back and forth, from one department to another.

“So, this patient was unconscious. We assumed it was a uremic case because he had chronic kidney failure. But we also realized that it could be a hemorrhagic stroke caused by heparin during hemodialysis. Anyway, the Emergency Room (ER) physician referred him to internal medicine. From internal medicine, the patient was referred to neurology and referred back to internal medicine. Eventually, a CT scan was performed, and it was indeed a hemorrhagic stroke. So, we consulted the neurology department. Unfortunately, the patient died before therapy was given” [Participant No. 1]

He thought this case might be caused by ineffective communication among the medical team members, including inadequate information reported by the student and ER physician during the referral consultation process.

Discussion

Issues regarding substandard care due to limited facilities and resources were also found in previous studies in Indonesia (24–26). This finding was consistent with those

of another study, where problems of justice and quality of care were ubiquitous in Indonesia, compared to the Netherlands (24). The same concern was also observed by medical students who took an international health elective rotation in low-resource countries such as Nepal, India, Ghana, Kenya, South Africa, and others (11,14). Patient overload, as found in the present study, is closely related to disparities in the number of healthcare providers between urban and rural areas in Indonesia. The shortage of physicians in rural areas is influenced by multiple factors, such as low population and limited healthcare infrastructures, closely related to the geographical factors (15, 27). Banyumas region is located in the rural area of the Central Java Province where reaching the capital city of Central Java takes five to six hours by car or train. Around 1.8 million population live in Banyumas, who are mostly low educated and graduated from elementary school. The general physician to patient ratio in Banyumas is 17.8 per 100,000, below the national standard; 43 per 100,000.

However, medical practice nowadays should focus on patient-centered care, instead of the old-fashioned one-way consultation style. Physicians should have a holistic view of the patients, including psychological and social aspects, instead of only focusing on the disease (28). A study from China shows that physician's high patient load has negatively affected patient-centered care (29). The government's policy regarding physician

distribution is needed to resolve this systemic problem of health inequality.

However, limited healthcare resources might be associated with other issues related to privacy in this study. Patient's privacy and confidentiality should be maintained in healthcare service. A previous study showed that not every patient in developing countries might have the same degree of privacy. Physicians might not be aware of patient rights, including protecting privacy and confidentiality (30). Patients from South East Asia mostly agreed to all physician's actions, due to their paternalistic relationship (31). However, the situation might differ between patients in cities and urban and rural areas, mainly due to differences in the level of knowledge and how they perceive their rights and responsibilities within the physician-patient relationship. Patients coming from a low level of education and low socio-economic class might not be aware of their rights, and most of them have no courage to request further (32, 33). Such lack of awareness results from an emergent social distance between physician and patient (34).

In addition, limited healthcare resources might have both positive and negative impacts on medical training. Students may have more experience in managing ethical dilemmas in patient care due to this limitation. However, as shown in previous studies, inadequate number of healthcare workers may lead to the exploitation of medical students and their burnout (35, 39).

Burnout might affect students personally and professionally, including decreased empathy and increased dishonest behaviors (37). Medical students may experience emotional exhaustion, symptoms of depression, and low sense of personal accomplishment when compared to residents and early career physicians (35). Several factors associated with students' burnout were as follows: (i) poor learning environment, (ii) inadequate support from faculty staff and colleagues, and (iii) limited opportunities for clinical coaching received from supervisors (37). Nonetheless, while mentally and physically exhausting for students, medical clerkship should be designed to improve students' experience and knowledge.

Financial issues remain a crucial part of the healthcare system. Financial difficulties were uncommon in similar studies from western countries, but were observed by medical students from Indonesia and India (7,24). Indonesia has implemented JKN as a national health insurance scheme since 2014 to bridge disparities of healthcare access. However, JKN faced a financial deficit, resistance from health professionals, and suspected management failure since its release (40). The financial deficit might be caused by catastrophic diseases covered by JKN, such as cardiac diseases, cancer, thalassemia, and others. Unethical practices such as bloody discharge, upcoding, and unnecessary readmissions could further increase the deficit. Through Indonesia Case-Based Groups (INA-CBGs), the

Indonesian Ministry of Health has regulated a pathway for health providers to improve cost-effectiveness. The system of INA-CBGs includes the rate of every service in patient care (e.g., physician consultation, workups, and treatment) based on a national drug formulary.

Nevertheless, meticulous budget control might negatively affect the quality of care. Balancing the quality of care and cost-effectiveness is challenging for medical practice (41, 42). Extensive and intensive discussions among insurance representatives, hospital management, and attending physicians can help plan and budget medical care as well as find solutions when funding is limited.

Delayed emergency treatment due to issues of consent was a case found in the present study. A body of evidence confirms that issues related to respecting patient autonomy, including informed consent, are recurrent ethical problems encountered by medical students in their clinical training (7, 9, 10, 12). However, informed consent in an emergency setting was complicated as multiple factors were involved. In this case, no family member or guardian were available to give consent, leading to obscurity of the patient's funding. Hospital staff may face difficulties in determining who will guarantee patient's medical bill payment. Although the Indonesian government had stated that every patient in an emergency condition should have first-aid regardless of funding, such

implementation is challenging. In rural areas where health funding is limited, financial uncertainty would be problematic for hospital management. Some hospitals also faced delays in insurance claim payments, which further increased their financial burden (43). Government and healthcare providers should discuss and find appropriate solutions for such dilemmatic conditions.

In Indonesia, the implementation of informed consent is not always ideal. Informed consent is an indispensable part of respecting patient autonomy. Nevertheless, informed consent is sometimes perceived as a legal protection for the physician against potential lawsuits. Hence, the focus changes from respecting patient autonomy to obtaining patient's signature. Unfortunately, patients often sign the consent form without fully understanding the procedure they are going to experience (44). Regarding informed consent, Indonesia's Ministry of Health has published a specific regulation stating that informed consent is not needed during an emergency and life-saving procedure⁴. While physicians are required to uphold beneficence and prioritize patient's interest in emergency cases, they might hesitate to perform an emergency procedure without written consent – even though it is permitted by law – due to potential risks of being reported for malpractice. Lately, physician criminalization and lawsuits regarding medical malpractice in Indonesia escalated due to increased awareness of patient rights and self-determination .

Various issues related to professionalism were prevalent in previous studies, such as inappropriate or rude behavior of healthcare personnel and dishonesty (5, 7, 24). Professionalism is related to clinical competence, communication skills, and ethical and legal understanding (45, 46). As part of honor and integrity, physicians are expected to be faithful and truthful; however, dishonesty and fraud are not uncommon in healthcare settings (47). Falsifying medical records is an example that is also predominant in other regions in Indonesia, as well as in other countries (48, 49). In some cases, specific working environments might force healthcare workers to falsify medical records (49, 50).

Issues regarding fake CPR were also found in other countries, in form of slow code, defined as less rigorous resuscitative efforts or prolonged CPR than usual (51). It was more of a symbolic gesture than an effective medical intervention. Families want to be involved, engaged in patient care, and treated respectfully during CPR (52); however, slow code is still ethically debatable (51).

Issues of student harassment were also found in the present study. Harassment in medical school is not unheard and still exists (53, 56). A study from Pakistan reported that around 28% of medical students were exposed to varieties of harassment, such as verbal, sexual, or physical abuse. Supervisors were reported as the most frequent offender (56), whereas they are

expected to offer students an excellent example of behavior as part of the hidden curriculum (57). However, reporting harassment was dilemmatic for students, let alone confronting the offender directly. Significant obstacles to reporting harassment in workplaces include fear of retaliation from the abuser and shame (58). Although considered less powerful, medical students could discuss their problems and difficulties during training with their peers and reachable supervisor. Bullying and harassment awareness should be increased through open discussions and consultation.

Other vital aspects of professionalism required in qualified health care are inter-professional collaboration and effective communication. A previous study showed improvement in at least one outcome following inter-professional collaboration (59). Decent quality of teamwork and coordination among healthcare providers from different disciplines can lead to better understanding of patients' problems, thus preventing mistakes and unnecessary disadvantages in health care (60). Collaborative clinical reasoning and shared decision-making of different health professionals are two core processes needed to solve patients' medical conditions (61). Effective communication among healthcare workers is also crucial in emergency cases involving several specialties (62). Emergency physicians should know which specialist should be consulted and prepare sufficient medical information before the

consultation. They are expected to be professional, pertinent, and anticipative (63). However, emergency physicians might face difficulties due to conflicting values, beliefs, and perspectives with their colleagues (64).

Medical students also experienced issues regarding termination of life such as euthanasia and ending of life's support devices (9, 10, 24, 65). However, these issues were not emphasized by the present study's participants. Indonesian patients and their families are less likely to request life support termination due to predominant social-cultural-spiritual context that differs from that of Western countries. Moreover, euthanasia is not legally permissible in Indonesia as it is forbidden by the current law and regulations (66). Thus, the participants hardly experienced such issues, especially in Indonesia's rural area.

Strengths and Limitation

This phenomenology study provided a better understanding of medical students' experience in managing ethical issues during their clinical rotation. However, more studies with larger sample sizes are needed to investigate ethical issues encountered by medical students during their clerkship in other rural settings, as well as urban settings, in Indonesia. Future research, using mixed quantitative and qualitative studies, can provide a more robust understanding of ethical issues observed by medical students.

Conclusion

Ethical issues observed by medical students in this study were related to limited facilities and resources, healthcare financing and issues of consent, as well as unprofessional behavior of healthcare providers. Many ethical issues related to substandard care were strongly associated with limited resources and complexities within the healthcare system. Early exposure to recurrent ethical problems in healthcare can help students prepare for their future career as a physician in a rural setting. To provide more real examples of ethical issues, new strategies in ethics education are needed to provide students with a deep understanding. However, this study's results may or may not be limited to specific rural areas, as no similar studies have been conducted in urban settings in Indonesia.

Acknowledgements

The funding of this study was from research grant "Riset Peningkatan Kompetensi" from Lembaga Penelitian dan Pengabdian Masyarakat Universitas Jenderal Soedirman (grant number B/53/UN23/14/PN/2019).

Conflict of Interests

The authors declare no conflict of interests related to the study, and they are exclusively responsible for the content and writing of this article.

Authors' Contribution

The research proposal was developed by MF. Interviews were performed by RBW, MF, and DL. RBW, MF, DL, and ANH analyzed the data and discussed it further with AM. Manuscript writing was led by RBW and further developed by MF, DL, and AM. All authors have read and approved the final manuscript.

References

1. Carrese JA, Malek J, Watson K, et al. The essential role of medical ethics education in achieving professionalism: the Romanell Report. *Acad Med.* 2015; 90(6): 744–52.
2. Myers MF, Herb A. Ethical dilemmas in clerkship rotations. *Acad Med.* 2013; 88(11): 1609–11.
3. Karnieli-Miller O, Vu TR, Holtman MC, Clyman SG, Inui TS. Medical students' professionalism narratives: a window on the informal and hidden curriculum. *Acad Med.* 2011; 86(1): 124–33.
4. Kenny NP, Mann K V, MacLeod H. Role modeling in physicians' professional formation: reconsidering an essential but untapped educational strategy. *Acad Med.* 2003; 78(12): 1203–10.
5. Sturman N, Farley R, Jennings W. Exploring medical student experiences of ethical issues and professionalism in Australia. *International Journal of Practice-based Learning in Health and Social Care.* 2014; 2(2): 88–95.
6. Bloch S. Medical students and clinical ethics. *Med J Aust.* 2003; 178(4): 167–9.
7. Rose A, George K, T AD, Pulimood AB. Survey of ethical issues reported by Indian medical students: basis for design of a new curriculum. *Indian J Med Ethics.* 2014; 11(1): 25–8.
8. Mejia RB, Shinkunas LA, Ryan GL. Ethical issues identified by obstetrics and gynecology learners through a novel ethics curriculum. *Am J Obstet Gynecol.* 2015;213(6): 867.e1-867.e11.
9. Nikavaran Fard N, Asghari F, Mirzazadeh A. Ethical issues confronted by medical students during clinical rotations. *Med Educ.* 2010; 44(7): 723–30.
10. Stites SD, Rodriguez S, Dudley C, Fiester A. Medical students' exposure to ethics conflicts in clinical training: implications for timing UME bioethics education. *HEC Forum.* 2020; 32(2): 85–97.
11. Elit L, Hunt M, Redwood-Campbell L, Ranford J, Adelson N, Schwartz L. Ethical issues encountered by medical students during international health electives. *Med Educ.* 2011; 45(7): 704–11.
12. Stites SD, Clapp J, Gallagher S, Fiester A. Moving beyond the theoretical: medical students' desire for practical, role-specific ethics training. *AJOB Empir Bioeth.* 2018; 9(3): 154–63.
13. Ege Moller J, Ronn Clemmensen C, Abdullahi Mohamed N, et al. Medical students' perspectives on the ethics of clinical reality. *Dan Med J.* 2020; 67(4): A10190600.
14. Bowsher G, Parry-Billings L, Georgeson A, Baraitser P. Ethical learning on international medical electives: a case-based analysis of medical student learning experiences. *BMC Med Educ.* 2018;18(1):78.
15. Mulyanto J, Kunst AE, Kringos DS. Geographical inequalities in healthcare utilisation and the contribution of compositional factors: a multilevel analysis of 497 districts in Indonesia. *Heal Place.* 2019; 60: 102236.
16. Laksono AD, Wulandari RD, Soedirham O. Regional disparities of health center utilization in rural Indonesia. *Malaysian Journal of Public Health Medicine.* 19(1): 158-166.
17. Padilla-Diaz M. Phenomenology in educational qualitative research: philosophy as science or philosophical science. *International Journal of Educational Excellence.* 2015; 1(2): 101–10.
18. Saunders B, Sim J, Kingstone T, et al. Saturation in qualitative research: exploring its conceptualization and operationalization. *Qual Quant.* 2018; 52(4): 1893–907.

19. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. 2004; 22(2): 63-75.
20. Braun V, Clarke V. *Successful Qualitative Research: A Practical Guide for Beginners*, 1st ed. London: SAGE Publications Ltd; 2013.
21. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*. 2017; 16(1): 1–13.
22. Guion LA, Diehl DC, McDonald D. Triangulation: establishing the validity of qualitative studies. *EDIS*. 2011; 2011(8): 3.
23. Karsten J, Jehn K. Using triangulation to validate themes in qualitative studies. *Qualitative Research in Organizations and Management An International Journal*. 2009; 4(2):123-50.
24. Muhaimin A, Willems DL, Utarini A, Hoogsteyns M. What do students perceive as ethical problems? a comparative study of Dutch and Indonesian medical students in clinical training. *Asian Bioethics Review*. 2019; 11(4): 391–408.
25. Barber SL, Gertler PJ, Harimurti P. Differences in access to high-quality outpatient care in Indonesia. *Health Aff (Millwood)*. 2007; 26(3): w352–66.
26. Syah NA, Roberts C, Jones A, Trevena L, Kumar K. Perceptions of Indonesian general practitioners in maintaining standards of medical practice at a time of health reform. *Fam Pract*. 2015; 32(5): 584–90.
27. Laksono AD, Ridlo IA, Ernawaty E. Distribution analysis of doctors in Indonesia. *Jurnal Administrasi Kesehatan Indonesia*. 2020;8(1): 29-39.
28. McCabe R, Healey PGT. Miscommunication in doctor–patient communication. *Top Cogn Sci*. 2018; 10(2): 409–24.
29. Ting X, Yong B, Yin L, Mi T. Patient perception and the barriers to practicing patient-centered communication: a survey and in-depth interview of Chinese patients and physicians. *Patient Educ Couns*. 2016; 99(3): 364–9.
30. Humayun A, Fatima N, Naqqash S, et al. Patients’ perception and actual practice of informed consent, privacy and confidentiality in general medical outpatient departments of two tertiary care hospitals of Lahore. *BMC Medical Ethics*. 2008; 9(1): 14.
31. Claramita M, Van Dalen J, Van Der Vleuten CPM. Doctors in a Southeast Asian country communicate sub-optimally regardless of patients’ educational background. *Patient Educ Couns*. 2011; 85(3): e169–74.
32. Unnikrishnan B, Trivedi D, Kanchan T, et al. Patients’ awareness about their rights: a study from coastal South India. *Sci Eng Ethics*. 2017; 23(1): 203–14.
33. Zulfikar F, Ulusoy MF. Are patients aware of their rights? a Turkish study. *Nurs Ethics*. 2001; 8(6): 487–98.
34. Claramita M, Nugraheni MDF, van Dalen J, van der Vleuten C. Doctor-patient communication in Southeast Asia: a different culture? *Adv Health Sci Educ Theory Pract*. 2013; 18(1): 15–31.
35. Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, Shanafelt TD. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med*. 2014; 89(3): 443-51.
36. Ishak W, Nikravesh R, Lederer S, Perry R, Ogunyemi D, Bernstein C. Burnout in medical students: a systematic review. *Clin Teach*. 2013; 10(4): 242–5.

37. Dyrbye L, Shanafelt T. A narrative review on burnout experienced by medical students and residents. *Med Educ.* 2016; 50(1): 132–49.
38. Adarkwah CC, Schwaffertz A, Labenz J, Becker A, Hirsch O. GPs' motivation for teaching medical students in a rural area-development of the Motivation for Medical Education Questionnaire (MoME-Q). *PeerJ.* 2019; 7: e6235.
39. Alkhamees AA, Alaqil NS, Alsoghayer AS, Alharbi BA. Prevalence and determinants of burnout syndrome and depression among medical students at Qassim University, Saudi Arabia. *Saudi Med J.* 2020; 41: 1375-80.
40. Erniaty E, Harun H. Understanding the impacts of NPM and proposed solutions to the healthcare system reforms in Indonesia: the case of BPJS. *Health Policy Plan.* 2020;3 5(3): 346–53.
41. Smith SK, Nicolla J, Zafar SY. Bridging the gap between financial distress and available resources for patients with cancer: a qualitative study. *J Oncol Pract.* 2014; 10(5): e368–72.
42. Warsame R, Kennedy CC, Kumbamu A, et al. Conversations about financial issues in routine oncology practices: a multicenter study. *J Oncol Pract.* 2019; 15(8): e690–703.
43. Yuliyanti C, Thabrany H. Delayed claim payment and the threat to hospital cash flow under the national health insurance scheme in Indonesia. [cited on June 2021]; <https://scholar.ui.ac.id/en/publications/delayed-claim-payment-and-the-threat-to-hospital-cash-flow-under->
44. Susilo AP, Nurmala I, van Dalen J, Scherpbier A. Patient or physician safety? Physicians' views of informed consent and nurses' roles in an Indonesian setting. *J Interprof Care.* 2012; 26(3): 212–8.
45. Mueller PS. Incorporating professionalism into medical education: the Mayo Clinic experience. *Keio J Med.* 2009; 58(3): 133–43.
46. Stern DT. *Measuring Medical Professionalism.* New York: Oxford University Press; 2006.
47. Stowell NF, Martina S, Nathan W. Healthcare fraud under the microscope: improving its prevention. *Journal of Financial Crime.* 2018; 25(4):1039–61.
48. Sheldon T. Dutch neurologist found guilty of fraud after falsifying 438 case records. *BMJ.* 2002; 325(7367): 734.
49. Mercer SE, Tino A. Falsifying medical records: a systems approach investigation. *Journal of Nursing Regulation.* 2011; 2(3): 41–3.
50. Vatikawa A, Amnawaty A. Medical record data counterfeiting by doctors in Indonesia reviewed from the ethics, discipline, and legal aspects. *Fiat Justisia.* 2018; 12(3): 224–33.
51. Lantos JD, Meadow WL. Should the “slow code” be resuscitated? *Am J Bioeth.* 2011; 11(11): 8–12.
52. Sak-Dankosky N, Andruszkiewicz P, Sherwood PR, Kvist T. Preferences of patients' family regarding family-witnessed cardiopulmonary resuscitation: a qualitative perspective of intensive care patients' family members. *Intensive Crit Care Nurs.* 2019; 50: 95–102.
53. Binder R, Garcia P, Johnson B, Fuentes-Afflick E. Sexual harassment in medical schools: the challenge of covert retaliation as a barrier to reporting. *Acad Med.* 2018; 93(12): 1770–3.
54. McClain T, Kammer-Kerwick M, Wood L, Temple JR, Busch-Armendariz N. Sexual harassment among medical students: prevalence, prediction, and correlated outcomes. *Workplace Health Saf.* 2021;69(6):257-67.

55. Fnais N, Soobiah C, Chen MH, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med.* 2014; 89(5): 817–27.
56. Ahmer S, Yousafzai AW, Bhutto N, Alam S, Sarangzai AK, Iqbal A. Bullying of medical students in Pakistan: a cross-sectional questionnaire survey. *PLoS One.* 2008; 3(12): e3889.
57. Lempp H, Seale C. The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ.* 2004; 329(7469): 770-3.
58. Easteal P, Ballard AJ. Shutting-up or speaking-up: navigating the invisible line between voice and silence in workplace bullying. *Alternative Law Journal.* 2017; 42(1): 47–54.
59. Martin JS, Ummenhofer W, Manser T, Spirig R. Interprofessional collaboration among nurses and physicians: making a difference in patient outcome. *Swiss Med Wkly.* 2010; 140: w13062.
60. Vyt A. Interprofessional and transdisciplinary teamwork in health care. *Diabetes Metab Res Rev.* 2008; 24(Suppl. 1): S106–9.
61. Hanum C, Findyartini A. Interprofessional shared decision-making: a literature review. [Jurnal Pendidikan Kedokteran Indonesia] *The Indonesian Journal of Medical Education.* 2020; 9(1):81-94
62. Kessler C, Kutka BM, Badillo C. Consultation in the emergency department: a qualitative analysis and review. *J Emerg Med.* 2012; 42(6): 704–11.
63. Guertler AT, Cortazzo JM, Rice MM. Referral and consultation in emergency medicine practice. *Acad Emerg Med.* 1994; 1(6): 565–71.
64. Finlay S, Sandall J. “Someone’s rooting for you”: continuity, advocacy and street-level bureaucracy in UK maternal healthcare. *Soc Sci Med.* 2009; 69(8): 1228–35.
65. DuVal G, Clarridge B, Gensler G, Danis M. A national survey of U.S. internists’ experiences with ethical dilemmas and ethics consultation. *J Gen Intern Med.* 2004; 19(3): 251–8.
66. Haeranah, Patittingi F, Muhadar, et al. Health and law: euthanasia in Indonesian legal perspective. *Enfermeria Clinica.* 2020; 30(4): 492–5.