A cross cultural journey through ethics education

Medical ethics teaching during the clerkship in Indonesia and the Netherlands

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To my A-team: Anton, Aya, Asri, Arselan

Invite all to the way of your Lord with wisdom and kind advice (teaching), and only reason with them in the most courteous and gracious manner.
(Q.S. An-Nahl 125)

A Cross-Cultural Journey through Ethics Education
Medical ethics teaching during the clerkship in Indonesia and the Netherlands

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CHAPTER 1

GENERAL INTRODUCTION

Introduction: From clinical practice to education

The end of 1999 marks the beginning of my journey as a medical doctor, or general practitioner *(Bahasa Indonesia: dokter umum)* to be precise. Before officially graduating and obtaining my practice license in January of 2000, I was offered to help my colleagues and work under supervision of a more senior medical doctor in a small 24-hour clinic in the heart of Semarang, a large city with a population of three million and the capital city of Central Java, one of the most populated provinces in Indonesia. The small clinic was located within the area of *Pasar Johar*, the central market of Semarang. One day, an old lady in her 60s came to the clinic with a simple complaint of itching on her upper back. I was shocked to see that there was a large growing mass with a diameter of 15 cm, like a shower cap attached on her upper back, as the source of the itching. I remembered thinking for a few seconds about what kind of tumor it was, but as I helped her put back on her thin *kebaya* (traditional Javanese clothing), I was more concerned about how she felt and what she had done, or where she had gone all these months (or years) for her tumor. Apparently, she had never gone to a doctor before because she had no *serious* complaints and because she had no money. I asked if it was okay if I referred her to the hospital, but she said it was not necessary because she would not be able to afford the costs[1]. That day I thought much about the case and wondered… *it seems there is something missing in my medical training… we never discussed about these kinds of issues, how to deal with patients that could not afford treatment or health care, how far is our responsibility in such situations, etc.*

[1] The national healthcare insurance *(JKN)* program had not yet been introduced at that time, although there was a social safety net or health care insurance for the poor *(Jamkesmas)*. The JKN program was first launched on the 1st of January 2014 (https://sehatnegeriku.kemkes.go.id/baca/rilis-media/20140101/479441/presiden-luncurkan-bpjs-dan-jkn/).

Shortly after graduation, I went to Jakarta to gain more experience in practice, while waiting for a job interview in Yogyakarta. I spent another three months working in two 24-hour clinics. My concerns about my medical training grew bigger as I encountered other dilemmas during my practice. First, I was questioned by the owner of the first clinic, a middle-aged lady, why I only gave Paracetamol for a patient. I innocently said that the patient only had some mild headache due to fatigue and work stress. She suggested that I add some other medications, at least some vitamins, next time I see a similar patient, to make it *more convincing*. So, after the incident, I would add some multivitamins to any patients who (actually) only needed one medication, to make it *more convincing*, as the owner said. Another case was at the second clinic, where I was *kindly reminded* by the owner to give a sick leave letter next time a patient asks for it. Apparently, a previous patient, a young university student came to the clinic for the second time after having been refused the letter during my practice. I refused to give the student the letter because she had been absent in class two weeks ago, in which she claimed that she was ill, and needed the letter for campus administration. I did not explain the situation to the owner but kindly apologized, as one would in Indonesia, and said yes to her request. During the three months, I often reflected on the cases and thought about whether my actions were right or wrong, while praying and hoping that I would never meet such clients again.

During this period of my professional life, I had asked many of my friends and colleagues, general practitioners, what to do and how to deal with such issues. Unfortunately, almost all said that I should just follow the orders and not think too much about it, which was confusing and disappointing for me. I then continued my practice in Yogyakarta, in a small child and maternity hospital, where I had more freedom to make my own decisions. At this point, I realized that there were many things that could be improved in clinical practice, and that many of the shortcomings were caused by the lack of knowledge or ignorance from our then medical training system. It was not always that people had bad intentions, but sometimes they just did not know or realize that what they were doing was potentially harmful, or even *unethical*, a word that had not occurred in my mind before. In 2003, in search for more learning opportunities, I found the Center for Bioethics and Medical Humanities of the Faculty of Medicine, Universitas Gadjah Mada, where I worked part time as a research

assistant and facilitator in ethical case discussions for medical students in the bachelor's phase. During this period, I realized that although great challenges lie ahead, there is still much room and opportunity to improve ethics teaching in medical training. Therefore, I decided to further explore and pursue my interest in medical ethics education.

Aim, objectives, research questions

My experience as a general practitioner in Indonesia, working in perplexity and not knowing how to deal with various ethical issues and dilemmas in clinical practice, led me to reflect on my two years of clinical (clerkship) training. This brought me further to the following questions: What ethical issues have we (me and my fellow clerks) encountered as a medical student during the clerkship phase? What do medical students need to be able to deal with those issues later in practice? As ethics teaching has developed much since the last two decades, both locally and globally, I also wondered if medical students elsewhere, especially in developed countries, face similar problems during their clerkship training. How are they similar or different? And what kind of ethics teaching do they receive as clerkship students in other countries? A comparison between countries will enable us not only to discern specifics in ethical issues, but also to view both students' and teacher's perspectives and needs more clearly, offering us more thinking options for how to improve ethics education for medical students in clinical training.

This study wishes to explore medical ethics teaching in two different countries, Indonesia and the Netherlands, in particular during the clerkship phase. We chose to focus on this subject and this phase for two reasons. First, students encounter real patients in the hospital during this phase and become a member of the medical team, although they do not yet carry full responsibility. Thus, students might want to discuss ethical problems or dilemmas that they encounter with their teachers and supervisors. Second, medical ethics teaching in the bachelor's phase are relatively established in both countries, although far less in Indonesia; and there are numerous learning and teaching materials from various resources available for both students and teachers. We wanted to explore what is needed by medical students and teachers in ethics education during the clerkship phase. Furthermore, we wanted to see the differences as well as similarities between the two countries and what we can learn from each other. To reach

those aims, we need more knowledge on the perceptions and experiences of both students and teachers.

Therefore, the aim and objectives of our study led to the following research questions:

1. What do medical students perceive as ethical problems in their daily training?
2. What kind of ethical cases do medical students encounter during their clerkship?
3. What do students expect and need from ethics education during the clerkship phase?
4. What problems or challenges do teachers face in teaching ethics to medical students?
5. What do teachers perceive as the learning goals of medical ethics?

Methods

For this study, we decided to only use qualitative methods. Unlike many studies in medical education that use quantitative approaches, we decided to use a phenomenological approach because of the explorative nature of our study. Our objectives were not about learning methods, assessment, or technical procedures, which often need standardized measures so they can be generalized. Rather, we wanted to explore the perceptions, opinions, beliefs, and attitudes of students and teachers in learning and teaching ethics. For this purpose, we participated in group discussions and observed how students and teachers interact during the learning process.

We started the study by observing and participating in ethics group discussions with medical students, as part of their learning activities in the clerkship phase. This was done in two medical schools, one in Indonesia and one in the Netherlands. The two medical schools had recently started to organize ethics group discussions in the clerkship phase, so the discussions were already part of the existing learning strategies in the respective schools, and not a new intervention or method that was specially designed for this study. After each discussion, we invited the students through email (Dutch setting) or text messages (Indonesian setting) for an in-depth interview, where they were asked to share an ethical case that they experienced themselves, which they considered most interesting or memorable during their clerkship. This first part of data

collection was conducted from March 2016 to August 2017, resulting in a total of 18 participant observations and 15 in-depth interviews from both settings.

Table 1. Methods used for each question and chapter

No.	Questions	Methods	Subjects		Chapters
			Dutch	Indonesian	
1	Perception of ethical problems	Participatory observations (18 groups)	10 groups (112 students)	8 groups (50 students)	2
2	Ethical cases	In-depth interviews (15 students)	8 students		2
3	Learning needs		7 students		2 and 3
4	Challenges in teaching ethics	In-depth interviews (40 teachers*)	18 teachers *(14+4*)*	17 teachers	4 and 5
5	Learning goals of medical ethics		16 teachers *(14+2*)*	20 teachers *(17+3*)*	6

**Most ethics teachers (31 teachers: 14 Dutch and 17 Indonesian) took part in both studies (questions 4 and 5), while few others (9 teachers) only took part in either study*

The second part of the study was aimed at exploring teachers' experiences and perceptions. We conducted in-depth interviews with ethics teachers from November 2018 to October 2019. The semi-structured interviews consisted of two parts. For the first part, we asked teachers to share their experience in ethics teaching in the clerkship phase: what were the expected goals or what they considered most important for students, how satisfied they were in achieving the expected goals, the barriers and facilitators, and the challenges in teaching ethics to medical students. For the second part, we asked the teachers if, during their learning activities in class, they had received any alarming cases from students, which they considered potentially harmful for patients or for students themselves. We explored and analyzed how they responded or reacted to the case, or how they *would have* responded, in case they did not have such experience. In total, we interviewed 40 teachers: 20 teachers from 13 medical schools in Indonesia, and 20 teachers from all 8 medical schools in the Netherlands.

The context

Why Indonesia and the Netherlands?

This study was conducted in two countries: Indonesia and the Netherlands. Besides the historical ties, the idea started with the existing collaboration between the two countries in the field of medical ethics. Despite seemingly having similar goals in teaching medical ethics, discussions among teachers from different countries suggested that there were different perceptions about what ethics is and the overall learning goals of medical ethics. We started to wonder how those differences would affect the learning process and outcome of ethics teaching in the respective countries, and how it would relate to the overall learning goals of medical ethics, both globally and locally. Although this study was originally exploratory and not comparative in its design, it seemed logical and reasonable for us to make some comparison between the two countries for a number of reasons. First, medical ethics is rapidly globalizing, as we can also see from the growing literature worldwide. Second, comparing is a good way of learning, especially between different countries and cultures (Rittle-Johnson and Star 2011). By comparing, we can identify the similarities and differences, *how* and *why* they are similar or different, and learn how those different elements can or cannot be implemented in either setting (Knipping 2003; Simpson and Schoepf 2016). Third, there are strong historical ties between Indonesia and the Netherlands, particularly in the field of medical education during the Dutch colonial period. Since then, the medical curricula have adopted the western model which was more or less "transplanted" to the eastern context or situation (Mustika et al. 2019). Therefore, despite the long historical ties, fundamental differences in cultural, social, and educational system, remain between Indonesia and the Netherlands, which becomes another reason for us to make a comparison between the two countries.

Medical training: The Dutch – Indonesian ties

The first medical school in the Dutch East Indies (now Indonesia) was founded in 1849/1851 during the Dutch colonial period, when the school *Dokter Djawa* (Javanese Doctor), was established by the Dutch government to train young natives to treat smallpox. It later became STOVIA *(School ter Opleiding van Inlandse Artsen)* or School for Education/Training of Native Physicians in 1902 (Pols 2008; Hesselink 2011). In the 1950s, after the Indonesian independence, the American curriculum was implemented, after receiving international support from the United States and the World Health

Organization to increase the number of graduates and overcome the shortage of physicians in rural areas. However, in 1970, medical schools in Indonesia returned to the Dutch curriculum, after the evaluation showed that many schools still lacked teaching staff and facilities to implement the various learning methods in the American curriculum, which required a balance between lectures, laboratory, community, and clerkship. In 1984, Indonesia developed its own national curriculum, named KIPDI *(Kurikulum Inti Pendidikan Dokter Indonesia)*. It was a community-oriented curriculum and was implemented nationwide. The 1984 KIPDI I was then followed by KIPDI II, a content and discipline-based curriculum in 1995 (Mustika et al. 2019). In 2005, influenced by a changing paradigm in medical education globally, Indonesia introduced a competency-based curriculum (CBC) and a set of national standards for the medical curriculum or the so-called SKDI *(Standar Kurikulum Dokter Indonesia).* This included the problem-based learning (PBL) method that was first introduced by McMaster University Medical School in Canada and *reinvented* by the Faculty of Medicine of Maastricht University in the Netherlands (Servant-Miklos 2019), which was then adopted by several medical schools in Indonesia (Dibyasakti, Rahayu, and Suhoyo 2013).

Medical ethics in Indonesia

Medical ethics has been a mandatory subject in all medical schools in Indonesia since decades. During those years, lectures in medical ethics were limited to the Indonesian Medical Code of Ethics *(Kode Etik Kedokteran Indonesia),* or the so called KODEKI, and existing laws in health care. Lectures were given by senior professors who were medical specialists with some training in law or medico-legal and no formal background in ethics. The lectures often introduce the articles within the KODEKI and may include case examples of ethical violations or breaches of the code or existing law without further discussions in class. Moreover, the notion of an ethical problem or dilemma was lacking. The implicit assumption was that if we follow the rules, then it will prevent us from having to deal with ethical problems or dilemmas. The main goal of medical ethics, therefore, was to prevent physicians from falling into ethical misconducts. In the early 2000s, *bioethics* was introduced nationwide in conferences and workshops. It has introduced the notion of ethical principles and ethical dilemmas thus opened space for ethical discussions within the new medical curricula, which implements the problem-based learning method using various case scenarios for students to discuss.

In Indonesia, learning outcomes/competencies for graduates of medicine are formulated in the Standard of Competencies for Indonesian Physicians or the so-called SKDI. The framework consists of seven areas of competence: (1) Noble professionalism, (2) Personal development, (3) Effective communication, (4) Information Management, (5) Foundation of medical sciences, (6) Clinical Skills, and (7) Management of Health Problems. The learning competencies for ethics are stated clearly in the first area of competence, namely *'noble professionalism',* which serves as the basic foundation for medical education in the country (KKI 2012). Competencies under this area include: (a) Belief in God, (b) Moral, ethical and discipline, (c) Awareness and obedience to the law, (d) Social and cultural insight, and (e) Professional behaviour (KKI 2012). Although the expected learning competencies are rather well defined, discussions at the national level imply that teachers still have different perceptions concerning the learning goals and scope of medical ethics teaching.

Medical ethics in the Netherlands

Literature on medical ethics teaching in the Netherlands dates back to 1975, when Sporken discussed how medical ethics is embedded in a new type of medical education at Maastricht University (Sporken 1975), and De Wachter shared the experience of experimenting medical ethics teaching in the new curriculum at University of Nijmegen (De Wachter 1978). Sporken discusses the development of ethics as no longer about what is good and evil, but as the science which investigates human behaviour and therefore characterized as an evaluative subject in the form of ethical reflection. Similar to the Indonesian situation, he addressed that for centuries, medical ethics was merely the code of honor for physicians. However, there has been an evolution bringing forward the idea that medical ethics is not only about the doctor-patient relationship, but it should also focus on the health of individuals and society, the health care organization, and policies of the government. It should incorporate health care in all its facets as the object of critical reflection and evaluation. Sporken suggested that there should be two main goals of medical ethics, namely ethical reflection and having an ethical attitude. Medical ethics in the Netherlands is often taught by a theologian or philosopher, specializing in medical ethics. Occasionally, teachers in the medical faculty might include ethics in case discussions in their own disciplines, or the ethics

teacher is invited to attend interdisciplinary teaching sessions for medical students organized by the clinical departments.

In 1995, Ten Have discussed his comparative study on ethics programs in two medical schools in the Netherlands, at the University of Maastricht and University of Nijmegen. Ethics education in those two schools used different approaches. Maastricht used a case-oriented learning method, while Nijmegen focused on the methods of ethics and moral reasoning. Despite the different approaches, the objectives of both programs were somewhat identical, namely (1) to make students aware of the normative dimensions of clinical decisions, (2) to develop skills in analyzing the normative dimensions of clinical decisions, and (3) to develop skills in exploring and justifying personal decisions in clinical contexts (ten Have 1995). Since early 2000, moral case deliberation methods, similar to the Nijmegen Method, have often been used for ethics consultation in clinical settings in the Netherlands (Steinkamp 2003, Molewijk 2008, Stolper 2016). This includes the Utrecht Method, a reflective tool that was developed by the Dutch *Centre for Bioethics and Health Law* (currently called the *Ethics Institute*) of Utrecht University and frequently used for educational purposes (Bolt et al. 2015).

Recently, the Netherlands Federation of University Medical Centres (NFU) published a revised version of the medical training framework for Dutch medical students, or famously known as the *Raamplan* Artsopleiding (NFU 2020). The *Raamplan* is deduced from the CanMEDS (Canadian Medical Education Directives for Specialists) framework and consists of seven competence domains: medical expert, communicator, collaborator, leader, health advocate, scholar, and professional (NFU 2020; Frank 2015). Unlike the Indonesian framework (Frank 2015), the ethics competencies in the Dutch framework are spread throughout the seven domains and there is more flexibility and freedom to interpret the competencies, although the last domain *(professional)* seems to be the one largely related to the field of ethics. According to the framework, as a *professional*, *"the doctor works for the health and wellbeing of both individual patients and the population (groups) through an ethically responsible practice that complies with the valid norms of conduct and legislation, by ensuring his/her own personal health and wellbeing and by collaborating well with other care professionals"*.

Outline of thesis

This thesis contains seven chapters, starting with this first chapter of general introduction, followed by five main chapters, and concluding with a general discussion. The main chapters will start with students' perceptions, including their experience in dealing with emotionally disturbing cases, followed by teachers' perceptions, including the challenges they face in teaching ethics to medical students in their respective institutions.

Chapter 2: Students' perceptions

This first paper was aimed to answer our first and second research questions on what medical students perceive as ethical problems in their daily training and the kind of cases they encounter during the clerkship phase. We wanted to know what an ethical problem is for them and why they chose a particular case to present in class or to share during the interview. We also identified the kind of cases students perceived as having ethical issues or problems during their clinical clerkship. We compared the findings between the two settings, Indonesia and the Netherlands, and analyzed the differences as well as similarities. We discussed how different or similar they were, and why or what might have caused those differences or similarities.

Chapter 3: Dealing with emotions

This chapter is about dealing with students' emotions in class during ethical case discussions. The study is less comparative and was developed from our findings in Chapter 2. It answers our third research question on what students expect and need from ethics education during their clerkship phase. We found that students sometimes felt emotionally disturbed by the (ethical) cases they encountered during their training and that they were hesitant to share their emotions in class; and if they did, teachers sometimes felt or seemed uncertain on how to respond to those negative emotions expressed by students. We discussed why students had those negative (and positive) emotions and furthermore if we can question one's emotions.

Chapter 4: Teachers' perceptions

This chapter aims to answer our research question on what teachers actually perceive as the learning goals of medical ethics. We explored teachers' perceptions from both countries on what they think are the most important learning goals for medical

students, what they expect from students to be able to achieve or gain from learning ethics. We identified the expected learning goals from teachers and analyzed the differences and similarities between teachers from both countries. We discussed the main differences between the two countries as well as the subtle differences within the similar goals. Furthermore, we discussed if differences in learning goals among countries or regions are acceptable or if it might be problematic.

Chapter 5: Dealing with alarming cases (Indonesian perspectives)

This chapter is another follow up of our studies in Chapter 2 and Chapter 3. The topic was developed from our findings through participant observations in group discussions and in-depth interviews with medical students. In the Indonesian setting, in particular, we found that students sometimes bring in alarming ethical cases to discuss in class and that teachers felt uncertain on how to respond, on whether or not to intervene to prevent further harm. We wanted to explore this phenomenon from the teacher's perspective as well as answering our research question on the challenges teachers face in teaching ethics to medical students. We identified the types of alarming cases, teachers' responses, their arguments, doubts, and concerns in dealing with such cases.

Chapter 6: Dealing with alarming cases (Dutch perspectives)

This chapter is paired with the previous chapter and explores the same subject but from the Dutch perspective. Although far less discussed with students in class in the Dutch setting compared to the Indonesian, we also wanted to know if ethics teachers in the Netherlands have ever experienced receiving reports of alarming cases from medical students in class and what they would do when having to deal with such situations, where they think that the patient's and/or the student's safety is at stake. Teachers discussed whether they should remain neutral in class or if they should step in and intervene. Similar to the Indonesian setting, we described examples of alarming cases mentioned by teachers along with their responses and arguments.

Chapter 7: General discussion

This concluding chapter summarizes the main findings of this study from the previous chapters and discusses the implications of the findings in both settings. It also discusses further the specific topic in Chapters 5 and 6 on dealing with alarming cases by comparing the findings between the two countries. The chapter provides general

recommendations and suggestions for practice and further study in the field of medical ethics education in Indonesia and The Netherlands. It also reflects on the methodology, including the limitations and dilemmas that arose during the study. Finally, it includes a brief cross-cultural reflection from the author as a medical doctor, researcher, and ethics teacher from Indonesia upon conducting and completing this study.

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CHAPTER 2

WHAT DO STUDENTS PERCEIVE AS ETHICAL PROBLEMS?

A COMPARATIVE STUDY OF DUTCH AND INDONESIAN MEDICAL STUDENTS IN CLINICAL TRAINING

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Abstract

Previous studies show that medical students in clinical training face ethical problems that are not often discussed in the literature. In order to make teaching timely and relevant for them, it is important to understand what medical students perceive as ethical problems, as various factors may influence their perception, including cultural differences and working environment. The purpose of this qualitative study was to explore students' perceptions of what an ethical problem is, during their clinical training in the hospital, and compare the results from two different countries. We observed a total of eighteen ethics group discussions and interviewed fifteen medical students at two medical schools, in Indonesia and the Netherlands. Data were interpreted and analysed using content analysis. We found that students in both settings encounter problems which are closer to their daily work and responsibilities as medical students and perceive these problems as ethical problems. Indonesian students perceived substandard care and inequity in healthcare as ethical problems, while Dutch students perceived that cases which are not matters of life and death are less worthy to discuss. Our study suggests that there might be a gap between ethical problems that are discussed in class with teachers, and problems that students actually encounter in practice. Teachers should be aware of the everyday situations in clinical training which may be perceived by students as ethically problematic and should acknowledge and discuss these ethical problems with students as part of the learning processes in ethics education.

Keywords: ethics education, medical ethics, student perception, clinical training

Introduction

Twenty years ago, a third-year Canadian medical student addressed the importance of acknowledging student-specific ethical dilemmas in the curricula and stated that most contemporary ethics curricula in medical schools have failed to address these specific issues (St. Onge 1997). More recent studies showed that general practitioners have different perceptions on how terms like ethical problem and ethical dilemma apply in everyday practice (Braunack-Mayer 2001), while a study in Germany shows that teachers in medical schools were unable to identify ethical issues encountered by students in medical training, although they were familiar with ethical issues in healthcare (Chiapponi et al. 2016). Clearly, there is a persisting question on what medical students perceive as ethical problems and what they need from ethics education (Eckles et al. 2005). The concept of an ethical problem has actually been supported by a large body of literature in the field of bioethics and medical ethics. However, the concept and definition have developed since the old days of medical ethics and Hippocratic Oath, to the modern days of Bioethics (Kuhse and Singer 2009), while other literatures introduce the more narrowed definition of ethical problems as ethical dilemmas, implying that problems of conflicting moral principles and choices are essential (Beauchamp and Childress 2008; Jonsen et al. 2006; Lo 2013). In our experience as ethics teachers, we noticed that students often have difficulties to pinpoint ethical problems and they come up with different, often culturally and socially shaped, concepts of what constitutes ethical problems. Different health and education systems may add to that. Hence, medical students working in different settings may have different perceptions of what an ethical problem is. The varying "conceptual starting points" of students are at the same time crucial for the effectiveness of teaching and have not been explored. For this reason, we were interested in exploring what medical students perceive as ethical problems and compare students' perceptions from two different countries.

In the Netherlands, the Dutch Federation of University Medical Centres (NFU) published a framework to define the learning outcomes of Master programs in Medicine (Laan et al. 2009) elaborated from the CanMEDS 2015 Framework (Frank et al. 2015). In Indonesia, learning outcomes for graduates of medicine are formulated in the

Standard of Competencies for Indonesian Physicians or the so-called SKDI, where "ethics and professionalism" is the cornerstone for the overall competence of medical doctors (Konsil Kedokteran Indonesia 2012). Both frameworks suggest that physicians should be able to recognize ethical problems and make ethical decisions in healthcare practice. Despite similarities in framework, learning goals, and teaching strategies, previous discussions among ethics teachers and clinical teachers in the national and international level indicate differences in the cases or problems they bring up. In Indonesia, medical ethics is very much nuanced by issues of ethical behaviour, professionalism, and medicolegal, while ethical discourse in the international level more often discuss complex ethical dilemmas involving advance medical technologies and global health problems. Moreover, bioethics is relatively new in Indonesia, and therefore, not many teachers in medical schools are trained in ethics. These differences suggest that there might be different perceptions among students on what an ethical problem is. This is important for teachers to understand, to be able to identify students' learning needs, especially during their clinical training phase (clerkship) in the hospital. If we can understand what students perceive as ethical problems, then we will be able to identify relevant topics and develop the appropriate learning goals and strategies for ethics teaching. For this purpose, we conducted a qualitative study at two medical schools: in Indonesia and The Netherlands.

Methods

Organization

We have chosen two medical schools in this study due to similarities in the learning strategies used for ethics teaching in the clerkship phase. Both schools regularly conduct ethics discussions for clerkship students ("clerkship" denoting the clinical training phase) as part of their curriculum. The two schools have been collaborating to improve ethics teaching and facilitators from both schools have had similar training to facilitate ethics discussions and conduct ethical deliberations. Hence, despite slight differences in organization, both have important similarities in the teaching methods used, which is crucial for our study. First, ethics discussions in both settings are organized by a special unit or department dedicated for medical ethics. Second, they are conducted in small groups, facilitated by ethics teachers (not by clinical teachers), and conducted outside of their clinical learning environment. Third, students are free to choose their own ethical cases or problems, which they have encountered during

their clinical training. Students are not given a certain case nor presented with any scenarios from their teachers. The fact that students choose and discuss their own cases shows the concepts of ethical problems they use. For this study, we have kept the schools anonymized to avoid any consequences for research subjects as well as healthcare providers. Subjects are clerkship students, called "coassistant" in The Netherlands, or *"koasisten"* in Indonesia, working in a tertiary (referral) hospital. In the Netherlands setting, ethics discussions are conducted in three different sessions throughout the clerkship program, facilitated by ethics teaching staffs from the Section of Medical Ethics, Department of General Practice. It starts with a brief introductory session, followed by a case discussion a few weeks later, and a second round of case discussion in the third clerkship year. In all three sessions, students are asked to share their own ethical cases. In the Indonesian setting, students have one session of ethics discussion during their round at the Department of Forensics and Medicolegal, conducted in two consecutive meetings, facilitated by teaching staffs from the Department of Bioethics and Humanities. During the first meeting, students discuss briefly their own cases which they have submitted beforehand, and then together choose the two most interesting cases to discuss in-depth during the second meeting a week later.

Data Collection

Data were collected from March 2016 to August 2017. We conducted 18 participant observations, ten in the Netherlands and eight in Indonesia (Tables 1 and 2), and 15 in-depth interviews with seven Dutch students (C1–C7) and eight Indonesian students (K1–K8). For this study, classes in the Netherlands were carried out in English with students' agreement, while in Indonesia classes were carried out in Indonesian Language (Bahasa Indonesia). Dutch students were always free to speak Dutch if they had any difficulties, and facilitators or other students were always helpful to translate the words or main ideas into English. Students were informed about the study and were asked permission to have the discussion audio recorded and field notes taken. We explained that any data collected will be kept anonymous and unidentifiable to ensure both students' and facilitators' privacy and confidentiality. After each class, students were contacted through e-mail or text message and asked for an in-depth interview. A written consent, each in English and Bahasa Indonesia, was obtained at the time of interview. The semi-structured interviews were approximately 50–100 min in length.

Students were given the chance to recognize and define the ethical problems themselves. The interviews began with the question: "Could you tell me about an ethical problem you have experienced during your clerkship?" Questions were then formulated according to the interviewee's narratives and responses.

Table 1a. Participant Observations in the Netherlands

Group	Participants	Gender		Cases discussed
		Female	Male	
A.	First session – Introduction class (30 minutes)			
I	14	8	6	2
II	14	7	7	2
III	15	7	8	2
B.	Second session – Case discussion (60 minutes)			
IV	9	6	3	5
V	8	3	5	2
VI	12	5	7	12
C.	Third session – Case discussion (180 minutes)			
VII	9	4	5	9
VIII	9	4	5	9
IX	12	9	3	3
X	10	9	1	10
Total	**112**	**62**	**50**	**56**

Data Analysis

All interviews, observations, and coding were done by AM, and analysed using content analysis (Silverman 2006). Coding and analysis of the first three observations and interviews were checked separately by DW and AU and discussed until consensus was reached. We interpreted and analysed students' experiences to understand what they perceived as ethical problems. After thirteen observations and interviews, respectively, no new data were found, nor new codes were needed. In order to ensure data saturation, we conducted two more observations and two more interviews to ensure no new categories nor themes were obtained. This practice is important to ensure data saturation was reached (Fusch and Ness 2015). In this paper, we first grouped the cases based on existing literature to give a general description (Dickenson et al. 2010; Jonsen et al. 2006; Kushner and Thomasma 2001). We then analysed how students discussed the problems, what makes the problem ethical for them, and categorized their perceptions (Table 5). Some details of the cases have been modified to protect privacy and confidentiality of patients, healthcare workers, and students. Interpretations were

sent to participants to ensure their perspectives are correctly represented (Tong et al. 2007; O'Brien et al. 2014). Twelve out of fifteen students who were interviewed sent back their comments and none of them disagreed with the interpretations.

Table 1b. Participant Observations in Indonesia

Group*	Participants	Gender		Cases discussed
		Female	Male	
Ia	8	4	4	8
IIb	13	4	9	3
III[a+b]	8	5	3	4
IV[a+b]	9	7	2	9
V[b]	12	7	5	12
Total	50	27	23	36

**Observations were conducted in both sessions or either one (a = first session; b = second session)*

Results

The results of this study are presented in three sections. The first section is intended to give a general description of what kind of cases students shared in each setting (Tables 3 and 4). The second section shows students' perceptions of uncertainties regarding the concept or nature of what an ethical problem is. Finally, the third section presents five categories on what students perceive as ethical problems (Table 5) or what the nature of ethical problems are. In other words, what makes the problem an ethical concern from their point of view.

Table 2a. Cases submitted by the Dutch students

No.	Topics	Subtopics	Case description
1.	Privacy	Privacy	- Installing secret camera at home
2.	Forced feeding	Forced feeding	- Patients with anorexia
3.	Refusal of treatment	Refusal of treatment	- Patients refusing caesarean section - Schizophrenic patient with terminal renal disease - Patient with malignancy refuses surgery - Patient's spouse refuses adequate pain management - Parents refuse cochlear implant for their child - Psychiatric patient refuses birth control
4.	End of life	Withholding/withdrawing treatment	- Suicidal patient in critical condition - Newborn twin with severe illness
		Request for euthanasia/ physician-assisted suicide	- Patient with obsessive compulsive disorder - Family's request of patient with Alzheimer - Patients with depression
5.	Professional secrecy	Confidentiality	- Prisoner with guard in the examination room - Asylum seeker with shared psychotic disorder - Male patient discovered as female - Child with bruises, suspect of child abuse - Baron van Muenchhausen Syndrome
		Obtaining data without patient's consent	- HIV test request from fireman rescuer - Patients with sexual transmitted disease
6.	Procreational decisions	Sperm donation	- Patient with infertility
		Sex selection	- Single parents/unmarried/homosexuals - Facilitating ultrasonography for later sex selection
7.	Student's role and responsibility	Student's duties and responsibilities	- Informing serious diagnosis to patients - Drunk teenager with leukemia - Patient wanting to sue doctors in-charge - Copying patient's medical record - Student referring patient to hospital by car
		Questioning decisions from seniors	- Doctor sending ambulance instead of visiting patient - Neglecting patient's request for pain management - Surgeon relying on examination from student - Korsakoff syndrome with stroke symptoms - Late referral, newborn with hyperbilirubinemia
		Being professional	- Refuse to take pictures with the patients - Communicate with the patient's family

Table 2b. Cases submitted by the Indonesian students

No.	Topics	Sub Topic	Case description
1.	Privacy	Privacy	- No privacy for patients at the lowest class ward
2.	Professional secrecy	Confidentiality	- Patient with HIV: disclosing information to other healthcare workers
3.	Refusal of treatment	Refusal of treatment	- Retentio placentae: patient's refusal for treatment - Intracranial hemorrhage: family's refusal for surgery - Peritonitis and laparotomy: family refused surgery - Child with epidural hematoma: family refused surgery - Diabetic coma: family's refusal for resuscitation - Lower limb fracture: patient and family's preference for alternative treatment
4.	Patients without the capacity to consent	Disclosing information to family Incidental/unexpected findings	- The inmate with epidural hematoma: whose consent? - The 17-year-old girl with abdominal pain: should we tell the parents? - Hernia inguinalis: family's consent and death in the operating room - Atonia uteri: hysterectomy using husband's consent
5.	Lack of resources	Healthcare insurance Doctors' working hours	- Patients who cannot afford to pay - Problems dealing with the healthcare system and insurance company - Limited medication/treatment for patients covered by the national healthcare insurance - Doctor's workload and working hours
6.	Quality of Care	Unprofessional behaviour	- Being disrespectful to patients - Congenital disorder: doctor blaming the parents - Blaming healthcare workers in front of the patient - Severe head injury: Late arrival of the consultant
		Substandard care	- Caesarean section: evaluating a death case - Steven Johnson Syndrome: neglected patient - Patient's death and family's disappointment
7.	Student's role and responsibility	Student's duties and responsibilities	- Delivering bad news to patients and families - Complex bureaucracy and bending the rules - Dealing with conflicting orders
		Questioning decisions from seniors	- Taking family's consent for non-treatment - Admitting patients to the ward - Filling in medical records
		Training hierarchy and teamwork	- Being inferior and question of authority - Taking the blame from doctors and nurses - Keeping quiet and covering up mistakes

Description of Cases

Tables 3 and 4 give an overview of the cases. In the Indonesian setting, many cases were related to lack of resources and quality of care, while cases related to forced feeding, end of life, and procreational decisions were not present. Although most cases involved patient care, the ethical problems brought up by the students did not necessarily involve the patient, such as cases related to students' role and responsibilities, where the conflicts were mainly between students and their supervisor or other healthcare workers.

Is it an Ethical Problem?

Students in both settings were sometimes uncertain whether their cases were regarded as ethical problems. A Dutch student described that she did not know at first what an ethical problem is, when she was asked to submit a case. She asked her fellow student about this, but her friend was also not sure about it, because her case was not considered a real ethical problem by the facilitator when it was discussed in class.

> *"…and then when he (the facilitator) came to her case, they discussed it... He said, you know, when you check the criteria, this is not really an ethical problem. So, he explained that, so that you know. That is nice for her because otherwise she doesn't know..." (C4, female, 3rd year clerkship)*

One of the students in Indonesia also expressed his doubts, when he was asked if he had any ethical problems to share with during the interview:

> *"Hmm… ethical problem… yes, I do have some… the first has to do with the training system, being a coassistant, so it's not between a doctor and a patient… is that okay? I also have one about scheduling night shifts… but I'm not sure if it fits (as an ethical problem)…" (K6, male, final year clerkship)*

The student wanted to make sure that the case he was going to share was regarded as an ethical problem by the interviewer. After being informed that he was free to share any cases he perceived as an ethical problem, he then shared a case about his conflict with a nurse, who is known for bullying students in the operation room. Once, he had had the courage to kindly speak up to the nurse about this, which surprised the nurse. His ethical issue was that his action, while good in itself, might bring harm to himself or his fellow students.

Table 3. Students' perceptions of ethical problems

Coding (Dutch students)	Categories	Coding (Indonesian students)
Dilemmatic situation Conflicting opinions Conflicting choices Conflicting values Right or wrong Grey area	**Conflicting choices**	Dilemmatic Conflicting opinions
Rights Duties Responsibilities Professionalism Standards and regulations	**Duties and responsibilities**	Rules/regulation Standard procedure Question of authority Being professional Teamwork Being inferior Problems to communicate
Frustration Helplessness Difficult situation Something not right Emotionally difficult	**Emotionally disturbing situations**	Guilty Upset Resentful Speechless Disappointed Helpless Angry
Neglecting patients Unprofessional behaviour	**Problems of justice and quality of care**	Inability to pay Lack of resources Health care system Unprofessional behaviour Treating patients equally Poor quality of care Neglected patients Medical errors
Patient was not dying Not a matter of life and death	**Life threatening cases**	---

Both students had doubts on whether or not their cases would be considered as an ethical problem by their supervisor (in the Dutch case) or by the interviewer (Indonesian case). During the case discussions, facilitators in both settings did not always point out explicitly if the problems students brought up were indeed an ethical

problem or not. They would more often help students formulate the ethical problem, especially in the Indonesian setting, where students often have not yet formulated the ethical problem in their case reports.

Students' Perceptions

Five categories emerged from both settings, three of which were more prevalent in either setting; i.e., "problems of justice and quality of care" was more prevalent among the Indonesian students, while "conflicting choices" and "life-threatening cases" were more prevalent in the Dutch setting.

Conflicting Choices

Many Dutch students perceived ethical problems as conflicting choices. During an interview, a student shared a case which he also submitted for the class discussion, about a 60-year-old woman who was a healthcare worker and had acute anaemia. The medical team wanted to perform an endoscopy to find the source of bleeding, but the patient refused and instead wanted to have more blood transfusion. When asked what was most interesting and ethical about the case, he explained his perception of an ethical dilemma with conflicting choices:

> *"I think an ethical dilemma is something that is going the other way than you want … So, I want to go to route A and the patient wants to go to route B… and it's not the same route… because as a doctor, I think route A is the best, but the patient thinks, 'no… route A is the worse and I want to go to route B'…" (C5, male, 1st year clerkship)*

Another Dutch student described his case as a "grey area" between right and wrong, which cannot easily be determined using common norms or standards. The student spoke about his parents who wanted to install a video camera secretly at his grandparent's home to monitor their condition, without informing the grandparents nor their assistant. The idea was based on good intentions and may seem right, but it can be considered as a wrongful act because it violates the privacy of others.

> *"I think it is (difficult) because there is an ethical question… it's a grey area, between right or wrong." (Introduction class, male, 1st year clerkship)*

An Indonesian student, K5, also shared his experience during a night shift in the ER. The surgical resident on duty that night told K5 to refuse a patient with severe head

injury who was about to be referred to the hospital because he had to operate another patient. However, the ER doctor insisted that they receive the patient because they were a referral hospital in the region.

> *"(And the resident said) 'Please tell the ER doctor that we are full here'… So, I was really confused… what should I say to him… if I said yes, but the patient still came... there was only one resident here, and he will have to do it… but if I say no (disagree with the resident), I might get into trouble… And that was really the most dilemmatic moment of my clerkship…" (K5, male, final year clerkship)*

The student decided to tell the ER doctor as he was told to and was thankful that the ER doctor insisted on receiving the patient. Even if they could not operate the patient immediately, they could take care of the patient better than the previous hospital which had less resources.

Duties and Responsibilities

Students in both settings brought up ethical problems related to the student's role and professionalism. A Dutch student shared his case about a young mother in her early pregnancy who had severe headaches and fever. During the course of the illness, she suffered from severe pain in the legs. The doctors suspected sarcoidosis but could not perform radiological tests nor give any therapy because they were teratogenic. As much as he wanted to help the patient and her husband, he found himself helpless and accidentally said something which he had deeply regretted.

> *... So, in the end I said, well, with a lot of frustration out of myself, I said to him (patient's husband): 'Well, I wish we could do so much more... I wish we could just get the diagnosis or something', and then I just basically walked away... (C3, male, 1st year clerkship)*

He had questioned his role, his duty and responsibility, as a medical student and a future doctor. He discussed the importance of communication and professionalism in medical training and how it should be emphasized in ethics education. In another interview, an Indonesian student shared her concerns about students' task to get the patient's or family's signature on the informed consent form. She thought that such important tasks should be done by a physician or nurse who has a legal capacity. In many cases, the patient and family have not been given sufficient, if not any, information about the procedure.

> *"Well… it (the informed consent process) is often simplified… and the students are the ones who must get the signature, and even give the information…*

whereas I think this is an important thing, with legal implications… so an official hospital staff should be the one who can do it properly, to inform everything about the procedure, including the risks…" (K2, female, 2nd year clerkship)

Indonesian students shared similar cases, where they questioned orders from seniors, and question if students are allowed or competent to do certain procedures. Such as K7 who shared a case about a patient with generalized peritonitis, whose condition was deteriorating with severe pain. The resident on duty that night told K7 to inform the family that the patient was in bad condition and that there was nothing else they can do. She questioned whether such tasks, such as delivering bad news and taking consent for non-treatment, should be carried out by students.

Emotionally Disturbing Situations

Students from both settings shared cases particularly because they were emotionally disturbing. This category might be seen as somewhat overlapping with the previous (conflicting choices); however, we consider this as a specific category because not all students felt the problem that they brought up was emotionally disturbing for them. A Dutch student shared a case, which she also submitted for the group discussion, about a young woman with extensive psychiatric history who lived in an institution. The health personnel suggested the patient to use birth control. However, she refused and expressed her desire to have children. The student stated that her reason for choosing the case was because it was emotional, and it was the only case which really had a strong impression on her.

"It was more emotional… because it's closer (to me)… For me it wasn't about the birth control… It was more like… emotional, the whole patient and everything, and it wasn't confined to one (ethical) question… because you're intensely working with someone for weeks with such problems, you know… (C7, female, 3rd year clerkship)

In another interview, an Indonesian student, K4, shared her experience in the ER, when a 7-year-old boy was admitted with a persistent headache due to a head injury the day before. The child was diagnosed with epidural hematoma and planned for surgery, but the parents said they needed some time to think before giving consent. The nurse, student, and resident tried to convince the parents that the child needed surgery

urgently. But the parents insisted on bringing the child home and wanted to try an alternative (spiritual) medicine called "ruqyah."

> *"At that time, I felt resentful ('sebal') because we had warned them over and over that there is no medication for this, other than surgery; to remove the bleeding and repair the damaged blood vessel. But they still did not give consent… so I was very upset, and… well… everyone has the right to determine or decide what they want..." (K4, female, final year)*

K4 said that she felt helpless and regretted not finding out why the parents refused, whether it was due to their beliefs or economic reasons. She felt guilty and said that they should have done more to protect the child, although she doubted that they could perform surgery without the parents' consent.

Problems of Justice and Quality of Care

Many Indonesian students perceived inequity, lack of resources, and poor quality of care as ethical problems, while this category emerged far less from the Dutch students. One of the cases shared during the group discussion was about a young woman who was referred to the hospital by a midwife because of a retentio placentae. The midwife in the hospital tried to remove the remaining placenta. However, the patient said that she could not stand the pain and refused to continue the procedure. The patient's husband said that it was up to his wife, and after discussing with the patient's father, they decided to bring the patient home because she wanted to stay at home to take care of her other children because her husband had to work. Moreover, they did not have any health insurance. Another student also shared her concerns about the outpatient clinics in the hospital, where there are insufficient doctors for the patients, who mainly come from the lower class. In some outpatient clinics, there are more than 100 patients per day with only 2–3 min per encounter. The service is often not worth the long travel and waiting hours. Some patients complain and question the doctor's service to the students, and students become very uncomfortable and have no idea how to respond.

Another case was about a young man admitted to the ER after a traffic accident. The patient was alert but suffered from progressive epigastric pain and was suspected to suffer from internal bleeding. He was put on waiting list for a laparotomy because there were other emergency operations and only one resident on duty. Unfortunately, the patient's condition deteriorated, and he died during the operation. The doctor then

reminded everyone in the OR, especially the two students, not to disclose the incident to anyone. The students were told to bring the patient to the ICU, where he was to be declared dead. The students first agreed to keep quiet, but they eventually disclosed the case to their clerkship group to remind them that they need to evaluate patients more carefully to avoid similar cases. Through the discussion, we found that the case was very complicated, not only involving fraud and neglect but also complex bureaucracy and high workload of residents and students.

Life-Threatening Situations

During an interview, a Dutch student shared her experience working with her supervisor, who asked her to bring a patient with chest pain to the hospital by car. She realized later that it was not the right thing to do, and that they should have called the ambulance. When asked why she did not tell her supervisor afterwards about her thoughts, she said that it was not a matter of life and death, and luckily everything went fine.

> *"Well umm... that's a good question… at that time I was like, okay, she's not going to die, but it doesn't feel good... and she had to have more examinations, so that's why we decided to send her to the hospital... But... afterwards, I was like hmm... this is not the best idea ever... no... I shouldn't do this... (C2, female, 3rd year coassistant)*

Another student, C1, also brought up a case that she perceived as an ethical problem but did not dare to speak up about, because it was not really a matter of life and death.

> *"I don't know... I just thought it was not right or something... but it's not really a matter of life and death or something so that makes it... (thinking…) like if it was a matter of life and death, then I would of course say it to someone... but this was just really subtle..." (C1, female, 3rd year clerkship)*

Both students did not directly say that an ethical problem should be a matter of life and death. However, they thought that if they are not, they are not worth discussing with teachers and supervisors. In other words, if a problem is not life-threatening, then it is not a "real" or "serious' ethical problem.

Discussion

General Description of Cases

In this study, we found differences, as well as similarities, between the two countries with regard to the cases students shared ("Description of Cases"), although the differences do not indicate that those cases occur only in either setting. The topic of professional secrecy, for instance, was brought up more often by Dutch students. Although in Indonesia professional secrecy is regulated by the law (Indonesia 2009, 2012), the current situation suggests that privacy and confidentiality have not yet become a major concern for patients. This is perhaps due to the collective culture in Indonesia, and this might explain why fewer ethical problems were related to the issue of professional secrecy in the Indonesian setting. Topics of euthanasia and procreational decisions were also brought up more frequently by Dutch students, and hardly by Indonesians. This is not surprising given that euthanasia is illegal in Indonesia (Pradjonggo 2016), while many procreation-related technologies are highly controversial (Indonesia 2014), and therefore leave no space for such cases to occur in the hospital. Other topics, such as "lack of resources" and "quality of care", were more often brought up by Indonesian students. Students in the Dutch setting did not bring up any cases related to problems of healthcare access and limited resources. Although a few Dutch students questioned quality of care and decisions made by their seniors, their major concerns or questions were about their own role and responsibility as a medical student in that given situation, whereas Indonesian students often shared cases related to lack of resources, substandard care, and unprofessional behaviour as a reflection and concern of witnessing similar cases in the hospital in their daily work.

Similarities were also found, where two topics were often brought up in both settings, namely, "refusal of treatment" and "student's role and responsibility." However, there were contextual differences among the cases between the two countries. In the Dutch cases, patients or families refused treatment due to reasons of best interest for themselves or for their loved ones, while cases of refusal in the Indonesian setting were often caused by financial problems due to the patient's (or patient's family's) inability to cover healthcare costs, including problems with the healthcare insurance. These patients were autonomous, have the capacity for self-determination, but could not act or decide on the grounds of their best interest due to financial constraints. These reasons were not present in the cases from the Dutch setting. The topic of student's role

and responsibility in the Indonesian setting also differed slightly from the Dutch, where it was more nuanced with issues of authority, hierarchy, and complex bureaucracy, compared to the Dutch setting. Hence, cases from Dutch students involved fewer conflicts between students, supervisors, and other healthcare workers in the hospital. This general description of the cases students shared is intended to show the wide range of clinical cases students perceive as having an ethical problem, as often described in existing literature (Kuhse et al. 2015; Lo 2013). However, it does not really show what makes the problem an ethical problem from the students' point of view. Our study shows that students were sometimes uncertain on whether or not the problems they shared could be considered as ethical problems ("Is it an Ethical Problem?"). Although supported by a large body of literature, what is to be regarded as an ethical problem is sometimes unclear for students or perceived differently.

Perception of Ethical Problems

Similarities and differences from the five categories were also found between the two countries (Table 5). The majority of Dutch students perceived ethical problems as ethical dilemmas with conflicting choices, far more than Indonesian students, and some perceived that ethical problems which are not life-threatening are less worthy of discussion with teachers and supervisors. This is possibly due to a number of reasons. First of all, students came from two different social and cultural backgrounds, and worked in two different healthcare systems. Second, there was a difference in the learning process. Dutch students were given a set of criteria for their case reports by their facilitators, one of which led to an ethical dilemma, while Indonesian students had more freedom to choose any case which they felt problematic. Despite the given criteria, from the interviews, we found that Dutch students did not always perceive ethical problems as dilemmas. Previous studies have discussed how to trigger students to bring up ethical problems (Donaldson et al. 2010; Kaldjian et al. 2012). The advantage of having more distinctive criteria, as it is in the Dutch setting, is that the discussion can be more focused on achieving certain learning goals, for instance, to resolve ethical dilemmas. However, with more open criteria, as it is in the Indonesian setting, students do not feel obliged to select a case which best fits the criteria, while the goal is more focused on broadening perspectives.

Many Indonesian students perceived problems of justice and poor quality of care as ethical problems, while this category was mentioned far less by Dutch students. Concerns of quality care in the Dutch setting were more often due to unprofessional behaviour of healthcare workers rather than lack of resources, although concerns of unprofessional behaviour were far more prevalent in the Indonesian setting. We believe that substantial social and cultural differences between the two countries, including the healthcare system, play a major role in constructing students' perception, as they also influence the kind of cases students encounter. However, complicated ethical problems regarding healthcare systems and policy which are predominant in developing countries remain a difficult topic and are rarely discussed in the literature (Iserson 2018; Iserson et al. 2012). Another difficult topic which emerged quite frequently from the Indonesian setting was about unprofessional behaviour from healthcare workers leading to poor quality of care (Chaudhury et al. 2006). Vidal stated that unprofessional attitudes and behaviour in healthcare institutions are rarely reported due to fear of retaliation and lack of anonymity of reporting mechanisms (de Oliveira Vidal et al. 2015; Caldicott and Faber-Langendoen 2005). Furthermore, the organizational culture in Indonesia shows a large power distance within the hierarchy (Irawanto 2009), with students being inferior, often causing uncertainties and barriers in communication (Muhaimin et al. 2012). We suggest that such problems should be addressed and discussed by teachers and students, as it may cause declining empathy and ethical erosion of medical students if not handled properly (de Oliveira Vidal et al. 2015).

Despite the differences, students in both settings perceived ethical problems as problems related to duties and responsibilities, in particular related to their role as clerks. Similar to our study, ethical problems among third-year medical students in the United States were also related to daily problems concerning professional duties and specific issues (Caldicott and Faber-Langendoen 2005; Kaldjian et al. 2012), while Kushner and Thomasma's Ward Ethics (Kushner and Thomasma 2001) also discusses the "hidden" problems related to students' duties and responsibilities, describing their discomforts and distress in everyday clinical training. Sturman's study in Australia suggests that teachers should explore more common ethical issues which are relevant to students (Sturman et al. 2014). Students in our study also perceived ethical problems as emotionally disturbing situations. They feel closer and more emotional when dealing

with cases where they have more responsibility. Unfortunately, mainstream bioethics literature and models of ethical deliberation provide relatively little room for emotions. A study by Guillemin and Gillam discusses the importance of emotions and ethical reflection in ethics education (Guillemin and Gillam 2015; Guillemin et al. 2009), suggesting that emotions are important for moral sensitivity, to be able to recognize situations which are ethically problematic. However, addressing emotional responses can be difficult for medical students as they may feel embarrassed or fear that they would be judged negatively by their seniors.

Students' responses in our study suggest that, for medical students, the ethical domain may be broader than ethical dilemmas and conflicting choices, and includes definitions focused on responsibilities, emotions, notions of justice and quality of care. Despite similarities in the educational framework and source of teaching materials, we found differences in perceptions among clerkship students between two different countries. These differences suggest that social and cultural context play an important role in students' definitions of ethical problems. Nevertheless, students in both settings also shared similar problems and concerns with regard to their learning environment, especially related to their role and responsibilities as medical students.

Conclusion

Our study suggests that there may be a gap between ethical problems that are discussed in standard teaching classes and problems encountered by medical students in the real setting. We believe it is important for students to be able to share those problems, and for teachers to be aware and open to how students themselves define or recognize ethical situations to facilitate shared learning. In doing so, they can learn from students as well. Defining ethical problems rather narrowly as ethical dilemmas or conflicting choices might only capture a small range of medical students' views about the nature of ethical problems. Most importantly, we need to consider that there may be different approaches to understand the nature and process of ethics discussion and moral deliberation for the purpose of ethics teaching, especially in different settings. Hence, learning strategies should be adapted to accommodate everyday situations in clinical practice that are perceived by students as ethically problematic.

Limitations

In the Dutch setting, all classes observed, and all interviews were conducted in English, which is not the native language of the researcher nor the participants. Hence, slight misinterpretations might have occurred, although students rarely spoke Dutch during the classes (despite the opportunity given) and spoke English fluently. This study was conducted in two academic hospitals, and therefore, the results might or might not be similar elsewhere.

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Compliance with Ethical Standards

Competing Interests

The authors declare that they have no conflicts of interest.

Ethical Approval

This study did not have any direct contact or interventions with patients, and therefore was not required to apply for ethical approval from the research ethics committees of both institutions. All procedures performed in this study were in accordance with the ethical standards of the institutional and/or national research committee.

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CHAPTER 3

ETHICS EDUCATION SHOULD MAKE ROOM FOR EMOTIONS

A QUALITATIVE STUDY OF MEDICAL ETHICS TEACHING IN INDONESIA AND THE NETHERLANDS

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Abstract

Studies have shown that students may feel emotional discomfort when they are asked to identify ethical problems which they have encountered during their training. Teachers in medical ethics, however, more often focus on the cognitive and rational ethical aspects and not much on students' emotions. The purpose of this qualitative study was to explore students' feelings and emotions when dealing with ethical problems during their clinical training and explore differences between two countries: Indonesia and the Netherlands. We observed a total of eighteen ethics group discussions and interviewed fifteen medical students at two medical schools. Data were interpreted and analysed using content analysis. We categorized students' negative emotions based on their objects of reflection and came up with three categories: emotions concerning their own performance, emotions when witnessing unethical behaviours, and emotions related to barriers and limitations of their working environment. Our study suggests that addressing emotional responses in a culturally sensitive way is important to develop students' self-awareness. Teachers should be able to guide students to reflect on and be critical of their own thoughts and emotions, to understand their own moral values, especially when confronted with other individuals.

Keywords: *emotions, ethics education, medical ethics, medical students, clinical training*

Introduction

One of the teaching methods in medical ethics which enables students to share and discuss real cases is the ethics group discussion. During these discussions, students sometimes share disturbing ethical cases along with their feelings and emotions about the case. Teachers, however, may feel uncertain on how to respond to those emotions, or uncertain if discussing emotions is necessary as part of the teaching goal. Previous studies suggest that teachers rarely discuss or explore students' emotions during these ethical discussions (Leget 2004, Gillam et al. 2014). Teachers often discuss the cognitive and rational ethical aspects, but seldom discuss students' feelings and emotions. They also tend to focus on identifying and resolving ethical dilemmas (ten Have and Gordijn, 2014). This is actually logical and in accordance with one of the goals of ethics teaching, which is to enable students to practice ethical reasoning and ethical decision-making. However, ethics is not only about identifying and solving ethical problems (Leget and Olthuis 2007, Saltzburg 2014, Avci 2016). Ethics is also about recognizing personal values (Avci 2017) and critical reflection, which involve both rational and emotional capacities (Mackenzie 2007).

Ten Have argues that there are two main views in ethics education, namely the modest view and the broad view. The modest view aims to assist health professionals in resolving ethical problems or dilemmas, while the broad view focuses more on character building, to create virtuous individuals and health professionals (ten Have and Gordijn, 2014, Saltzburg 2014). In fact, many medical schools have proposed this broad view of ethics teaching within their curriculum (Carrese et al. 2015, Indonesia 2012, NFU 2009). We believe this broad view is ideal to achieve the goals within the medical curriculum, to prepare students to deal with the continuous changes, complexities, and uncertainties in healthcare (Campbell, Chin, and Voo 2007) and prepare them for the lifelong learning throughout their professional lives (Avci 2017). In this paper, we wish to explore students' emotions, including differences in the kind and extent of emotional discomforts, which might be related to cultural backgrounds; and discuss what ethics education, in particular teachers in ethics, can offer to students in this matter. It focuses on students' emotions and how they reflect on their emotions in dealing with disturbing cases. It is part of a larger study on ethics education in medical schools in the clinical training phase (clerkship), comparing two countries with

substantial social and cultural differences: Indonesia, a developing southeast Asian country; and The Netherlands, a developed western European country.

Method

The study was done at two medical schools, in Indonesia (INA) and The Netherlands (NL). They have been kept anonymized to avoid any consequences for research subjects and teachers, as well as health care providers. Subjects are clerkship students, namely students who are in their clinical training phase in the hospital. This phase refers to the last two years (Indonesian context) or three years (Dutch context) of their medical training. Ethics teaching in the clerkship phase has been organized sequentially, scheduled every 2–3 weeks, in a form of ethics group discussion (5–15 students) in both schools. As a preparation for the discussions, each student is asked to submit one ethical case which they have encountered during their clerkship. Students need to have at least completed three clinical rounds as one of the inclusion criteria. There were no exclusion criteria for our study, and we included all group discussions conducted between March 2016 and August 2017, with approximately six months of data collection in each setting. We received schedules for the group discussions and asked the facilitators beforehand if they were willing to have their classes observed, and for Dutch facilitators to conduct the discussions in English for the purpose of this study. Classes in the Netherlands were carried out in English with students' agreement, although students were free to speak Dutch if they wished to do so; while In Indonesia, classes were carried out in the original language, Bahasa Indonesia.

During a period of one year, we conducted a total of 18 participant observations (Table 1) involving 162 students (INA = 50; NL = 112) in total, and in-depth interviews with 15 students (INA = 8; NL = 7) (Table 2). Two participant observations were cancelled in the Indonesian setting due to changes in the schedule from the facilitators, while two others in the Dutch setting could not be analysed due to technical problems. All Indonesian students were of Indonesian origin and all Dutch students were of Dutch origin. Due to differences in the teaching organization and time allocation for the group discussions, the number of groups, participants, and cases which were discussed, differed between the two countries. Moreover, not all cases submitted were discussed in class. We informed students about the study, asked their permission to have the discussion audio recorded, and explained that all data will be kept anonymous and

unidentifiable to ensure students' and teachers', as well as patients' and healthcare workers', privacy and confidentiality. After each class, students were contacted through e-mail (Dutch setting) or text message (Indonesian setting) and asked if any of them was interested to be interviewed for the study. A written consent, each in English and Bahasa Indonesia, was obtained at the time of interview; and interviews were done in Bahasa Indonesia for the Indonesian students and in English for the Dutch students.

Table 1. Participant Observations

Indonesia			The Netherlands		
Group*	**Participants**	**Cases discussed**	**Group**	**Participants**	**Cases discussed****
I(a)	8	8	I	14	2
			II	14	2
II(b)	13	3	III	15	2
			IV	9	5
III(a)	8	8	V	8	2
III(b)			VI	12	12
IV(a)	9	9	VII	9	9
IV(b)			VIII	9	9
V(a)	12	12	IX	12	3
V(b)			X	10	10
Total	**50**	**36**	**Total**	**112**	**56**

**Discussions were conducted in two sessions:*
(a) all cases discussed briefly
(b) two to three selected cases from the first session discussed more in depth
***Facilitators grouped cases with similar topics and discussed one case from each topic*

This paper focuses on students' feelings and emotions. The two words are used interchangeably in this paper, although there have been discussions suggesting different meanings between the two. In our study, we observed how students discuss their cases in the small groups, including how they expressed their emotions. We then explored their experience and emotions further during the interviews. Although students sometimes expressed their feelings spontaneously when sharing the cases, we explored this further using questions such as: *"How do you feel about the case?"* or *"Could you describe how you felt at that time?"* Different questions were then formulated according to students' narratives and responses (Silverman 2006, McGrath, Palmgren, and Liljedahl 2018). All data collection, including observations, interviews,

and coding were done by AM, while categories and content analysis were checked together with DW and discussed until consensus was reached. We began with looking at how students expressed their feelings and analysed how they reflected on their emotions, and then made a categorization based on their objects of reflection (Ottesen 2007, Schutz et al. 2006). Interpretations of transcripts were sent to participants to ensure their own meanings and perspectives are correctly represented (Tong et al. 2012, O'Brien et al. 2014, McGrath, Palmgren, and Liljedahl 2018). All participants responded positively, and Indonesian participants have suggested minor corrections for the English translation of terminologies and nuances.

Table 2. In-depth interview with students

Indonesia		**The Netherlands**	
Female	Male	Female	Male
4	4	4	3
8		**7**	

Results

We analyzed how students reflected on their emotions based on their objects of reflection and came up with three categories: reflections based on emotions related to oneself *("not performing well enough")*, to the other *("witnessing unprofessional behaviour")*, and to their working environment *("boundaries and limited resources")*.

Not performing well enough

This first category shows how students can feel emotionally disturbed by their work performance. It is part of the student's reflection on oneself, on how well they have performed at work and what could have been done better. A Dutch student shared a case during an interview, which he considered emotionally difficult and expressed his frustration several times. The case was about a young mother who was in eight weeks of her pregnancy who had severe headaches and fever. The doctors suspected sarcoidosis but could not prove it because the radiological tests would need a contrast which was teratogenic, nor could they give any medication because it was also teratogenic. After two weeks in the hospital, the patient suffered from severe pain in the legs, so she was given epidural pain medication. The case was complicated and

stressful for the medical team, but it became particularly stressful for the student because of a small incident. For this reason, he enthusiastically shared this particular case.

> *"...I stood on the side, and I just looked at the numbers go up, and I was like... please let this end as soon as possible… and then when we arrived at our floor, we both walked out... I mean I couldn't just walk away, so I looked at him and he looked at me... and I was like (said), 'Well, good luck!', and I felt so stupid immediately... because it was such a... I don't know... like… (as if he said) 'Well f*** you, you should do something!' or something like that... and well… he said 'Yeah thanks'.... and... it became very uncomfortable. I wanted to make him feel more at ease, like help him out, and I couldn't, and that was so annoying, so frustrating, and I didn't know how to cope with that!" (C3, male, 1st year clerkship)*

The student found himself in an awkward situation where he met the patient's husband in the elevator. He did not know what to say and eventually said something he had deeply regretted. The incident was shocking for him and caused negative emotions and distress. Furthermore, he described how he reflected very much on the case in the weeks after and even thought of taking the stairs more rather than the elevator to avoid similar incidents. He considered himself as having behaved unprofessional, and that he could have done better.

In another interview, an Indonesian student also shared her experience during her round in surgery, when a seven-year-old boy was admitted to the emergency room (ER) with a persistent headache due to an accident the day before. The child was diagnosed with epidural hematoma (EDH) and was planned for surgery. At this point, the parents did not give consent and said they needed some time to think. The nurse, student, and neurosurgical resident had respectively discussed with the parents and tried to convince them that there was nothing they could do other than to perform surgery. The resident also stated that the child had a good prognosis. But the parents insisted on bringing the child home because they wanted to try an alternative (spiritual) medicine called "ruqyah".

> *"Well… we missed (the opportunity) … and the patient was brought home. So… I just feel sad, thinking… there was this kid, who couldn't decide for himself, and his parents perhaps were not well educated… and they decided for 'ruqyah' instead… (sighing…). Because then I also realized… an EDH needs urgent surgical treatment, and if it's an emergency then you don't necessarily need an informed consent, right? Although… (thinking…) in this hospital, you will*

always need a (written) consent for everything, including cases like EDH, which is considered an emergency." (K4, female, 3rd year clerkship)

The student said that she was disturbed by the case, feeling upset, resentful, and helpless at the same time. During the interview, she expressed her feelings, admitting that she was quite exhausted that day with only two students on duty, and that she regretted not knowing the reason why the parents refused, whether it was because of their belief or financial reasons. She realized afterwards that the medical team should have tried harder to protect the child who could not speak for himself. Although it had been almost a year since the case, she sometimes thought about the case with guilty feelings, especially when dealing with paediatric patients.

Witnessing unprofessional behaviour

In our study, students from both settings shared cases in which they witnessed perceived unethical or unprofessional behaviour from their superiors and co-workers. During an interview, a Dutch student mentioned that she had brought up her case particularly because it was emotionally difficult and disturbing for her. During her round in obstetrics, which she experienced more than a year, she had observed a few cases where she felt quite sure that the health personnel on duty had intentionally neglected the patient's request for pain medication during labour and did not communicate or discuss it with the patients. The health personnel said that they would pass the request to the anesthesiologists, but in fact did not do so until it was finally too late to give pain medication when the anesthesiologists came.

"I have seen one midwife who will wait until she was 6 (the dilatation) so she couldn't get it anymore because she thought that it was not necessary, but then I thought… 'I'm sorry, but she's asking for pain medication... Isn't it your job then to call the anesthesiologist'? I really had some ethical problem with this, because I thought... I don't know... I think you're not really taking her (the patient's) request seriously... What I found disturbing is that this is really sensitive... a really sensitive field... and I felt that the women that were working there… they were losing their empathy towards their patients or something, and THAT I found disturbing." (C1, female, 3rd year clerkship)

Although the patients did not complain, the student thought that it was not right. She had discussed the case with her fellow students, but many thought differently about the case. Her peers believed that the midwives were protecting the patients from their own decisions because there are also risks of getting an epidural anesthesia. However, she had a different way of thinking and strongly believed that as health personnel, they

should have respected the patient's wish and communicate better with the patients. The student never brought up the case in the group discussion because she thought it was not a serious ethical case. Nevertheless, she still felt disturbed by the case and wondered if any of the patients had said something about it to the hospital or to the doctors afterwards.

In the Indonesian setting, a student presented a case during a group discussion about a 40-year-old woman who was admitted to the ER late afternoon. The patient was unconscious with a Glasgow Coma Scale (GCS) of 6, diagnosed with EDH, and planned for surgery by the surgical resident. The students said that the process of admitting the patient to the operation room took quite long, especially because they had to wait for the anaesthesiologist. Around 8 pm, the patient's GCS had dropped to 3, so the resident decided not to operate and informed the family that the patient's condition had deteriorated and was too risky for the operation. After 15 min the patient passed away and the anaesthesiologist finally arrived. When he was told that the operation had been cancelled, he replied: *"So why didn't you tell me (that the operation was cancelled)?"* – referring to his disappointment of coming there for nothing. The students felt disappointed and resentful at the same time but were relieved that the patient's family accepted the situation because the resident had explained beforehand about the slim chances of the operation.

During another group discussion in Indonesia, students brought up a case about a surgeon whom they considered very rude to patients, especially during his work at the outpatient clinic. *"He is often harsh to patients and does not listen, simply ordering them to open their clothes, take a glimpse at the wounded area, write a prescription, and say nothing else while the patient gets escorted out of the examination room by the nurse",* students said. When asked by the facilitator how they felt about working with the surgeon, the majority of students said that it was stressful and uncomfortable being in their position. Their task was to assist the surgeon and they felt ashamed and sorry for the patients. Interestingly, one of the students said that he was not that disturbed. He said that he could understand the surgeon's act considering the number of patients and limited time, and that he actually likes the surgeon because he is willing to share his knowledge despite his busy schedule and usually gives good grades to

students. The student said that the surgeon is also actually quite funny, which he considered important for doctors and clinical teachers, to light up the stressful situation.

Boundaries and limited resources

For this third category, all cases came from the Indonesian setting, where students dealt with complex bureaucracy and scarcity on a daily basis. In an interview, one of the students shared a case during his round in paediatrics. He said that he was actually not in charge of the patient, nor was he on duty; but he felt concerned about the case, which he had heard from his colleagues who were on duty that night. One evening, there was a child admitted to the ER diagnosed with encephalitis and referred to the ward.

> *"The patient reached the ward around 11 pm, if I'm not mistaken… then around 1 am the (patient's) condition deteriorated… so they reported the condition to the consultant on duty that night… and the consultant referred the patient to the HCU (High Care Unit). But at that time, the HCU was full, so the patient could only be admitted to the HCU around 4 am… then there was an empty bed at the ICU (Intensive Care Unit), so he was then referred to the ICU… but then around 7 or 8 am the patient died. So, my concern was… if the patient's condition was already poor since the beginning (in the ER), why did he have to go all the way to the ward? Why didn't they send him directly to the HCU or ICU? They should have done better than that!" (K3, male, 3rd year clerkship)*

The student said that he was puzzled and felt disappointed about the situation. He tried to make sense of the case and said that there might have been many patients in the ER at that time, so there might have been some information missing or cases of miscommunication between the doctors in the ER and the consultant. He said that this had not been the first case and that students were concerned. From the group discussions, we found similar cases where students felt disappointed and resentful about the healthcare and training system. Students often questioned the complicated bureaucracy and poor communication among medical staff in the hospital and felt helpless about their working environment.

During one of the group discussions, another student shared her concerns about doctors' workload at the outpatient clinic. She gave an example of dr. X, who is a surgeon. In one day, he has to do a follow up of all his patients in the ward, do the outpatient clinic, and perform surgeries. In the outpatient clinic there are more than 100 patients per day for one doctor, which means 3–4 h of outpatient service for 100 patients, only 2–3 min of encounter, and no time for questions. The service is often not worth the long travel to the hospital plus waiting hours and did not satisfy the patients,

who are mostly from the lower class. Patients often looked puzzled because they were not well informed about their illness and on what was going on. Students felt concerned about this and felt sorry for the patients. The limited number of doctors also had a negative impact on patients in the wards. Students said that they sometimes "did not follow the rules" or bend the rules for patients' sake. This included actions such as skipping or jumping the line within the training hierarchy in case of emergencies, buying their own blood pressure monitor for patients, or collectively buying an oxygen mask for a patient due to the lack of medical equipment in the hospital.

There were also multiple cases where students felt concerned about the lack of facilities in the hospital. There is sometimes lack of privacy because the rooms are limited, with no walls or curtains in between, so other patients can sometimes hear and see what is going on. The inpatient wards are divided into different classes (VIP, I, II, III) according to patients' financial ability and the type of health insurance. Hence, patients in the lower classes have less privacy and facilities, and sometimes different medication and treatment. Students often felt concerned and helpless at the same time because they could not do anything. Adding to the unjust situation is the fact that healthcare workers are often given special privilege to cut the queue and have more privacy. When students were asked how they felt about having such privilege as future doctors, students had different feelings. Many expressed their doubts because it was unjust, although they admitted that it is tempting for them. Surprisingly, one of the students clearly expressed his opinion that they deserve to have that privilege and that he would be happy to use it for himself and his family in the future.

Discussion

Reflection and self-evaluation

In medical training, students often feel worried by how well they can perform in front of their seniors and teachers and often feel distressed when receiving negative feedback (Good 1998). However, we found that students can also feel disturbed and distressed when they feel that their work or performance was not as well as they themselves expected in regard to patient care. They believe that they might have caused harm and contributed to poor outcomes of patients (Monrouxe 2012). This is also part of an ethical reflection related to one's responsibility to others, in this case the patients and their families (Burns 2017). We believe it is important to give some space and opportunity

for students to share such problems, in which they feel they might have been ethically responsible for the patient's wellbeing (Gillam et al. 2014, Guillemin and Gillam 2015, de Zulueta 2015). Although it is not always easy to share feelings about such problems in a group, we think it is important for students to learn that having negative emotions of oneself, such as guilt and regret, is normal and can be a good sign of self-reflection and self-evaluation, which is part of the broad view in ethics education (Branch 2005). Moreover, other students might have similar experience and can support each other and learn from the experience as well.

In this first category, we found similarities between the two countries. During the group discussions, students in both settings rarely shared cases in which they felt they have not performed well enough. We suggest that there might be two reasons for this. First, students often feel uncomfortable admitting that they made mistakes or did something unethical in front of their peers and teachers (Good 1998). While during the interviews, students had more freedom and time to express their thoughts and emotions in a relaxed atmosphere to the interviewer, who is not part of the training system. Second, some students may have a higher sense of responsibility for patients than others, considering that as clerkship students, they are not yet responsible for patients. Results of our study also show that in both settings, reflection and self-evaluation have not yet been incorporated much into the learning activities of the ethics clerkship curriculum. Moreover, the group discussion is the only form of ethics teaching during clerkship in both schools, although it is conducted slightly more frequently in the Dutch setting.

Discussing unethical behaviour of others

Previous studies have shown that at least 50% of medical students have witnessed unethical behaviour from their seniors and teachers during clinical training (Imran et al. 2014, Kovatz and Shenkman 2008, Okoye, Nwachukwu, and Maduka-Okafor 2017). Unfortunately, we have not found any literature on experiences from Indonesian or Dutch medical students regarding this topic, although this does not mean that acts of unethical behaviour do not occur or are more prevalent in either setting. Despite the large number of publications, there is limited discussion within those studies on what students thought and felt about their experience. It is clear however, from our study, that many Indonesian students shared negative feelings such as anger, disappointment,

frustration, regret, and resentment due to their experiences of witnessing unethical behaviour from their colleagues, seniors and teachers in their daily work. Our concern is that these negative emotions may lead to long term consequences such as emotional exhaustion and decreasing moral sensitivity (Monrouxe et al. 2015, Rushton 2017).

Cases of unethical behaviour, in our study, were more often brought up by Indonesian students, both in interviews and group discussions. There are perhaps two reasons for this. First, there is a huge difference in terms of the health care system as well as the education system between the two countries, characterized by a more paternalistic system in Indonesia. This may lead to students feeling disturbed by healthcare workers perceived as behaving unethically, while patients, on the other hand, might feel that they are just being treated normally like other patients. Second, there is a difference in the organization of the group discussions between the Dutch and Indonesian setting. In the Dutch setting, students are given a set of criteria for the cases which leads to an ethical dilemma; while in the Indonesian setting, students were free to share any cases which they felt problematic, without any certain criteria. Cases of unethical behaviour are often considered an ethical issue but not an ethical dilemma. Moreover, Dutch students have a mentor outside of their ethics education program, whom they can share their problems and concerns with, including problems about unethical behaviours of seniors. This might explain why there were less cases about this topic reported by Dutch students during the group discussions.

Working in a difficult/intrusive environment

In many countries, poverty and scarcity still provide the most difficult ethical challenges for health practitioners in their daily work (Olweny 1994) and "justice" is a difficult topic for ethics teachers to discuss with students. Today, medical students perhaps see this problem in a different perspective than their seniors. Since the emergence of bioethics education in medical schools worldwide, medical students are now "well equipped" with ethical principles and values. However, in situations where health care access and resources are one of the major issues, ethical principles such as autonomy and justice often become surreal and unrealistic for students, as described in our study. A number of Indonesian students expressed their concerns, that ethics teaching somehow becomes nonsense and useless (Bahasa Indonesia: *percuma* or *sia-sia*) in such an environment, referring to the fact that students can hardly do anything

in such situations. Respecting patient's autonomy become somewhat vague when patients actually do not have any, or limited, choices due to financial reasons and scarcity. At the same time, Dutch students hardly shared any emotional experiences on the topic of health care access and lack of resources. Hence, our study can perhaps contribute to the limited studies about students' experiences in working in a rather intrusive system and difficult environment with limited resources.

From our study, we learned that clerkship students in the Indonesian setting had numerous tasks, such as performing routine follow-ups, monitoring patients and night shifts duty, to support the overload work of their supervisors. This is very different from the Dutch training system, where clerkship students only encounter a limited number of patients in their daily work, far less than the Indonesian. With the relatively small number of patients and clinical tasks, Dutch students have more time to discuss clinical cases thoroughly with their supervisors and also have more free time outside of their clinical clerkship. Moreover, students in the Indonesian setting shared feelings of exhaustion, of being overwhelmed and of powerlessness (Bahasa Indonesia: *pasrah*) concerning their workload in the hospital. During one of the interviews, an Indonesian student admitted that he is actually often unaware of ethical problems going on in the hospital due to his workload, both academic and clinical. Therefore, although he appreciated and enjoyed learning ethics during the bachelor phase, he had doubts if it had any benefit for their clerkship phase, not because it was irrelevant, but due to the fact that there is hardly any time and space for ethical reflection. Insights from our study suggests that assigning clerkship students with too many clinical tasks might cause harm, even if it can benefit students in enhancing their clinical skills and is needed for the sake of patients. Teachers and physicians working in academic hospitals should be aware of this problem and try to balance the risks and benefits for both students and patients.

It is also interesting to learn from our study that students have sometimes taken actions based on their own initiatives and moral values for the patient's sake, despite their limited level of responsibility and the potential risks they bear as students towards their senior/superior. Whether or not students have taken any actions, such as not following orders or "bending the rules", students in the Indonesian setting shared mixed feelings of doubts and uncertainties, worries and guilt, in regard to their own decisions. In many

cases, students expressed feelings of relief after the group discussions, hearing similar experiences from their peers and receiving support from both peers and teachers for their efforts and courageous actions. Even though many students felt overwhelmed and simply accept the fact that they work in a hospital with limited resources, we believe that willingness from students to take such actions is a positive sign of moral resilience (Rushton 2017, Young and Rushton 2017). Although Rushton suggests that moral resilience is unlikely to flourish in environments that lack a culture of ethical practice, we suggest in contrary, that being in a rather intrusive environment and experiencing ethical challenges may trigger one's need for moral resilience, as opposed to being in a rather ideal or non-intrusive environment where everything is ethically and systematically well organized.

Questioning and educating emotions

Students may have diverse opinions and emotions in dealing with disturbing cases, as shown in our study. Some might have negative emotions, while others can be indifferent or uncertain on how to respond. However, some students might also have positive emotions while the majority find it disturbing, such as the two cases in our study where one of the students was not disturbed by the doctor's unprofessional behaviour of being rude to patients, and another student feeling fine with doctors having special privilege in the hospital while it was unjust for other patients. In such cases, teachers might feel uncertain on how to respond to these situations, as they fear that their honest opinions may stop students from being open and willing to share their thoughts and emotions. At the same time, teachers might have the feeling that such positive emotions in disturbing cases might be "not right" and worrying, in regard to students' sensitivity and moral development. Our question is whether we are allowed to question one's emotion and if emotions can be educated. Cates, in reviewing Martha Nussbaum's "Upheavals of Thoughts", stated that "emotions have some relationship to thoughts, especially to beliefs and evaluative judgments, and they are appropriately subject to critical reflection and moral evaluation". She also argues that some beliefs, which influence one's emotions, are sometimes false, and that it is good to correct false beliefs (Cates 2003). Therefore, we suggest that teachers can indeed question students' emotions and that it is possible to educate emotions. We believe that questioning one's emotion is needed to clarify one's beliefs and values, which is also an important step in the process of ethical deliberation.

In our study, there is a slight difference between the two settings with regard to how teachers facilitate the group discussions. Teachers in the Dutch setting used a more structured method compared to the Indonesian, which was more flexible and less structured. Therefore, teachers in the Indonesian setting had more opportunity to ask students how they felt after dealing with their ethical problems. However, students' reasonings were often not explored or discussed further, and teachers sometimes seemed uncertain on how to respond to students' emotional reactions. Gracia suggests that the role of teachers in this case should be neither "imperative" (indoctrinating values) nor purely "neutral" (value free). Rather, he proposes the so called "Socratic" or "deliberative" method, which emphasizes the practice of reasoning (Gracia 2016). Teachers should not judge the way students feel or think, but rather pose questions until the students themselves realize that what they feel, or think, is false. Differences in knowledge, experiences, and beliefs, indeed may cause different emotions among individuals. By guiding them through their reasoning, teachers can understand where the emotions are coming from, and students can understand their own emotions as well as reflect on their own knowledge, beliefs and values. One might say that this brings ethics discussion or moral case deliberation too close to psychological guidance or even psychotherapy. However, we believe that the difference between the two lies on the main goal or purpose. In ethics teaching, the main goal should be the practice of moral reasoning while also dealing with emotions, and not to enhance or improve one's mental health as in psychotherapy.

Conclusion

Findings from our study show that contextual and cultural differences play an important role in shaping students' perceptions as well as emotions in dealing with ethical problems. We found similarities from both settings with regard to students' emotions, in particular related to their satisfaction of their own performances as medical students, and to their evaluation of the work performances of others, namely other healthcare workers in the hospital. We found a difference, however, in regard to students' emotions related to the working environment; Indonesian students more often had negative emotions in dealing with ethical problems related to their training system as well as healthcare system, due to the limited facilities and resources in their workplace. Our study suggests that addressing emotional responses to ethical problems

in a culturally sensitive way is important to guide students in understanding their own character, by learning and reflecting from their own responses, as well as others. Ethics education, therefore, should provide room for students to express their emotions; and group discussions may be a perfect medium to achieve these goals by including emotional impacts as part of the structured method. Teachers, moreover, hand, should be prepared in dealing with students' emotions. Hence, teachers may need further training, to be able to guide students to be critical of their own thoughts and emotions, by reflecting on their own knowledge and beliefs.

Limitations

In the Dutch setting, all classes observed and interviews, were conducted in English, which is not the native language of the researcher nor the participants. Hence, slight misinterpretations might have occurred, although students rarely spoke Dutch during the classes (despite the opportunity given) and spoke English fluently. This study was conducted in two academic hospitals, and therefore, the results might or might not be similar elsewhere.

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Compliance with ethical standards

Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical approval

This study did not have any direct contact or interventions with patients, and therefore was not required to apply for ethical approval from the research ethics committees of both institutions.

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CHAPTER 4

DUTCH AND INDONESIAN TEACHERS ON TEACHING MEDICAL ETHICS:

WHAT ARE THE LEARNING GOALS?

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Abstract

Previous literature has discussed the different views, the diverse goals and scope of ethics education, and the need for a more homogenous curriculum in medical ethics. Since ethics is about values, and values are partly influenced by culture, we question to what extent teachers' perceptions concerning learning goals of medical ethics curricula are similar or different in two different countries, and if differences in learning goals are acceptable or problematic. We conducted in-depth interviews with 36 medical ethics teachers, 20 from Indonesia and 16 from the Netherlands, and explored what they think are the important learning goals. We found three similar goals, with slightly different perceptions, between the two groups: (1) being professional, (2) dealing with ethical problems, and (3) being part of society. We also found four other goals that differed between the two countries: (4) understanding one-self and (5) learning from others from the Netherlands; (6) being faithful/pious and (7) obeying rules/standards from Indonesia. We suggest that despite similar goals shared globally, there might be differences in how teachers in different cultural contexts perceive the goals with their local values and translate them into the curricula. Differences in learning goals are common and natural, often reflected by historical and sociocultural contexts, and should not become a barrier for teachers in different regions to collaborate. Understanding these differences may be an important goal for teachers themselves to broaden their knowledge and perspectives.

Keywords: *teachers; medical ethics; learning goals; Indonesia; Netherlands*

Background

Current developments in medical education have brought new educational frameworks for medicine in general and for ethics teaching in particular. Each country has its own framework that is often used as a starting point to develop their ethics curriculum. For instance, Dutch medical schools use the Medical Training Framework known as Raamplan Artsopleiding [1], while Indonesian medical schools use the Standard of Competencies for Indonesian Physicians (SKDI) [2]. Despite the thorough description of the scopes and expected competencies in clinical knowledge and skills, the scope and goals in ethics remain somewhat unclear and open to various interpretations. Hence, ethics curriculum in each medical school may vary according to teachers' perceptions and how they interpret and contextualize the educational framework into their curriculum. Leite et al. suggested that contextualizing the national curriculum may correspond better to students and their local situations [3], while Marulcu and Akbiyik's study showed that teachers often adopt the social reconstruction ideologies as their curriculum ideology to fulfil their perceived goals and personal beliefs of constructing a better society [4].

Previous studies have discussed the diverse views, scope and aim of ethics education, and the need of a consensus for a more homogenous curriculum in medical ethics [5–7]. However, since ethics is considered to be about values, and values are partly influenced by culture [8–10], we question to what extent the teachers' perceptions concerning learning goals of medical ethics curricula are similar or different in Indonesia and the Netherlands, and if differences in goals are acceptable or considered problematic.

The first step of curriculum development should include problem identification and general needs assessment [11]. Previous studies have identified various perceptions as well as diverse needs and preferences of medical students towards ethics curricula [12], including the ethical problems they encountered during clerkship [13,14]. These studies are important to support data and information concerning students' learning needs and to further develop an ethics curriculum that is most relevant and suitable to their respective conditions and contexts. Our previous study showed that there are similarities and differences between what Dutch and Indonesian students perceive as

ethical problems and what they might need and expect from their ethics training [15]. However, we do not know from the teachers' side, what they consider are the most important outcomes from ethics teaching and what they expect from students as future doctors through ethics education. This paper wishes to explore what Dutch and Indonesian teachers think are the important goals of ethics teaching, how they might be different or similar, and to describe and discuss the meaning of these differences and similarities in the development of medical ethics teaching globally.

This paper is part of a larger study on ethics education in the clerkship phase in Dutch and Indonesian medical schools. Historical ties between Indonesia and the Netherlands have paved the way for long-existing collaborations in education and research, including medicine and health. However, it has only been recently that the two countries have started to collaborate in the field of medical ethics education. The existing cultural, religious, social and educational structural differences between the two countries were most appealing for the authors to explore and compare the two groups. We believe that exploring and comparing the two groups of participants could bring more global understanding of ethics teaching and broaden teachers' knowledge and perspectives, especially among teachers in countries with very different social and cultural backgrounds, such as Indonesia and the Netherlands.

Methods

Our study used a phenomenological approach to explore the perceptions of ethics teachers in teaching medical ethics. We did not use any predetermined theory, nor did we intend to develop any new theory, but aimed rather to describe and discuss the experiences and perceptions of our subjects. We conducted in-depth interviews with purposive sampling. For the Indonesian setting, we collected names of teachers from our professional network of ethics teachers in medical schools, and from mailing lists of bioethics training courses and workshops. We then made a list of 25 teachers from 13 medical schools in Indonesia and selected 18 teachers with a diverse sample across teaching sites, demographic characteristics, and educational backgrounds. All 18 teachers who were invited agreed to participate, but one interview was eventually cancelled by the candidate due to competing tasks. After conducting 17 interviews, we found no new themes nor categories. However, we agreed to add three more teachers to ensure data saturation, and make sure that no new themes emerged. In total, we

interviewed 20 teachers from 13 medical schools in Indonesia. In the Dutch setting, we invited 15 teachers from all 8 medical schools in the Netherlands. One teacher did not respond, and three others referred us to other colleagues. We then added two teachers to ensure data saturation, adding up to a total of 16 teachers from all 8 medical schools in the Netherlands. In total, we conducted in-depth interviews with 36 teachers (IDN = 20, NLD = 16) from both settings (Table 1). Interviews were conducted between January and September 2019.

Table 1. Teachers' Characteristics

Characteristics		Indonesia (20)	Netherlands (16)
Sex	Female	9	8
	Male	11	8
Home base university	Public	15	13
	Private	5	3
Teaching experience	<5 years	5	3
	5-10 years	8	4
	>10 years	7	9
Education background	Health* (only)	16	-
	Humanities**	2	9
	Health + Humanities	1	5
	Health + Humanities + Law	1	2

*Health: medicine, nursing, medico-legal

**Humanities: ethics, humanistic, philosophy, theology

We contacted participants through e-mails (Dutch setting) and text messages (Indonesian setting) and sent consent forms through e-mail before the interviews. Almost all participants were familiar with one of the research team members, which was valuable in gaining trust and building rapport. Interviews were mostly conducted at participant's respective workplaces, two outside of their workplaces, six through telephone, and ranged from 40 to 120 minutes. We obtained permission to have the interview audio recorded and to take field notes during the interview. We explained that all data were kept anonymous and unidentifiable to ensure the teachers' privacy and confidentiality. In-depth interviews in Indonesia were conducted by AM, RBW, and DL in Bahasa Indonesia, while interviews in The Netherlands were conducted by AM and RBW in English. We used a semi-structured interview guide which was pilot tested to the first two participants in each setting. We asked participants to share their

experiences in ethics teaching, in particular during the clerkship phase, and what were the expected goals or what they considered most important for students learning ethics. Specific questions included how satisfied they were with their teaching experiences, in achieving the expected learning goals, the barriers and facilitators, and the challenges they face in teaching ethics to medical students. Further questions were then formulated according to participants' narratives and responses. The follow-up questions were meant to clarify the responses from participants and enhance the interviewer's understanding.

Coding and thematic analysis of the Indonesian findings were conducted by AM and DL, while coding and analysis of the Dutch findings were done by AM and MH. Codes, sub-categories, and categories related to expected learning goals were grouped manually using Excel sheets and tables. Categories were derived from the data and were checked against each other and with the original data set. Potential categories and sub-categories were discussed together with MF, AU, and DW until consensus was reached. AM, DL, and MF are medical ethics teachers in Indonesia, while MH and DW are medical ethics teachers in the Netherlands. AU is a professor of research methodology and qualitative methods in Indonesia, and not involved in ethics teaching. Interpretations of transcripts, including the English translations, were sent to participants through e-mail to ensure their own meanings and perspectives are correctly represented. Two participants did not respond, and two others gave clarification and minor corrections with suggestions on the English translation.

Results

Teachers' characteristics We interviewed a total of 36 ethics teachers with various educational backgrounds and length of teaching experiences (Table 1). Most teachers were based in public universities. The private universities were originally affiliated to religious foundations, i.e., Christian, Catholic or Islamic foundations. We found a difference in teachers' educational backgrounds between the two countries. Almost all Indonesian teachers were medical doctors without any formal training in the field of humanities, and seven teachers who were doctors had a subspecialty training in medico-legal, which is a subspecialty in medical forensics. Only two teachers in the Indonesian setting were not doctors and had formal training in ethics, philosophy, and

theology. On the contrary, all Dutch teachers had a formal education in the field of humanities, while less than half of them had a background in medicine and nursing.

Similar goals

We categorized teachers' goals from each setting and found three similar goals: *being professional, dealing with ethical problems,* and *being part of society*. Being professional in both settings meant that students should have an ethical and professional attitude and behaviour. Dealing with ethical problems includes being able to discuss ethical problems from different perspectives and give moral arguments and reasoning, while being part of society entails that students are able to blend into the larger society and working environment. Interestingly, we found different nuances within those similar categories (Table 2).

Table 2. Similar goals in medical ethics perceived by Dutch and Indonesian teachers

Categories	Codes	
	Dutch	**Indonesian**
Being professional	Professional attitude and identity	Professional behaviour
	Personal characteristics	Ethical mindset and attitude
	Moral sensitivity	Collaborate with others
	Being critical	Good communication
	Reflection	Being good role models
	Speak up	Being humane
	Integrity	
Dealing with ethical problems	Identify ethical problems	Identify ethical problems
	Different perspectives	Different perspectives
	Discuss ethical problems	Discuss ethical problems
	Learn to cope with problems	Solve ethical problems
	Moral decision and reasoning	Moral arguments
	Emotional risks	Ethical principles
Being part of society	Understanding environment	Maintain local wisdom
	Understanding workplace and culture	Cultural values
	Seeing the relevance in practice	Social justice
	Being part of a larger society	Social responsibility
		'Doctors for the nation'

1. Being professional

In the Dutch context, reflection was considered an important part of being a professional doctor. One Dutch teacher spoke about character education, explaining that attitude, personal characteristics, and personal virtues are very important in the

long term. He mentioned that students should be critical of their profession and discussed the importance of each person being responsible (assuming responsibility) when something goes wrong and not keeping silent. Students should be able to find a way to talk about challenging ethical and moral situations in a constructive and positive way. This view was also emphasized by another teacher who spoke about integrity and about having a speak-up culture.

> *"We have some kind of reflection… what does it mean to wear a white coat? We want them to think, to reflect on themselves, because they are socialized in a very particular way as medical students. They must behave in a certain way, and they start to behave in a certain way on the day they wear a white coat, and we reflect with them on what happens. There's a lot of socializing, discipline, and power involved, and it's hidden and implicit." (T008)*

> *"I think teachers should tell them about ethics and integrity, and I believe that human beings really know quite well what integrity is. We don't have to spell it out. We want to have integrity, we want to have a speak-up culture, we want to have a learning community… It's much more interesting to prepare them on being a person, being a professional for a life-long learning in knowledge and attitude." (T016)*

Slightly different, Indonesian teachers spoke about the importance of good role models with regard to being professional, not only as a learning method, but as a learning goal. They talked about the strong hidden curriculum, the presence of many bad role models and how ethics teaching should compensate for that deficit. Hence, teachers said that teaching ethics can be very challenging and almost 'impossible', as stated by one of the participants. Therefore, they expect students to become good role models for their juniors, to be humane, well-mannered and have good communication skills, because patients also take notice of these important values.

> *"One of the driving forces for bioethics education is role modelling. It is impossible… well, not impossible, but it is difficult for us to expect students to behave (ethically) and to give good moral arguments, when what they hear and see is morally incorrect. Here we explain things that are normative (good), then they return to the hospital and see those (bad) things again. Our fear is that students will not listen and just think 'these ethics lecturers are just talking, that's not what we see in reality!'. This gap is really my main concern, because it will affect the educational milieu." (G007)*

The teacher, who was a medical doctor himself, described his concerns about the difficult learning environment and his rather pessimistic view about teaching ethics in an 'unethical' environment. This concern was also shared by many other ethics teachers

in the Indonesian setting, who were mostly medical doctors. However, there were some respondents who thought that having both good and bad role models is an important part of the learning process in ethics education.

> *"I don't think it really hinders. Students say there are still many doctors who can become (good) roles models, especially senior ones, who are now elderly. But this doesn't mean that young lecturers cannot become role models, because students are actually more comfortable (interacting) with residents. Students also feel they can accept that real life is not always as ideal as they think. Sometimes they come to understand why a doctor does something (bad)… 'maybe because he was tired and so on'… and why a doctor ends up shouting at a patient, for example." (G016)*

Sharing the same view with other Indonesian teachers, the teacher thought that reflection is an important part of ethics education. Observing bad role models, in particular, can be a useful learning method to reflect on how students themselves think and feel about this dilemma, to encourage thinking about why someone would act or behave that way and come to better understand the circumstances, while also keeping in mind that the behaviour is unprofessional and something they should not do.

2. Dealing with ethical problems

This similar goal was more profoundly stated and described more often in the Dutch context compared to the Indonesian. Dutch teachers discussed the importance of taking distance from the case and to be aware of emotional risks, including moral distress and burnout, when dealing with ethical problems. For Dutch teachers, teaching ethics is not about solving ethical problems. One teacher stated that medical students tend to want to solve ethical problems because they are accustomed to problem-solving. He believes that it is more important to learn 'to live' and cope with a problem, try to deal with it as best as possible, and to accept that there might not be answers nor any solutions to the problem.

> *"The prime goal is to get students accustomed to ethical discussions, even if there is not an answer; try to make them bearable and acceptable and agreeable for everyone that is involved." (T005)*

For Indonesian teachers, dealing with ethical problems was often referred to in the context of finding a solution as the end goal. This is perhaps the most important difference within this category. One teacher discussed about the importance of understanding the basic moral principles in order to solve ethical issues that emerge in modern medicine. He stated that the medical code of ethics will not help much,

referring to the fact that in Indonesia, the code is often used as the main reference when dealing with ethical issues.

> *"I think, basically, there should be principle-based ethics, or the basic moral principles, because it is related to teleology and in accordance with advances in science and technology; while the code of ethics is more into deontology, to show what is good… So, if we only refer to the code of ethics, it will be frustrating because if there are advances in technology and a (ethical) dilemma, for instance a brain death case, we can't solve it only with deontology." (G014)*

3. Being part of society

The third similar goal is 'being part of society'. Dutch teachers expect students to be able to understand their environment and culture, blend into society, and see the relevance of their ethical knowledge in practice. One Dutch teacher explained that teaching ethics is about making students aware of the context, and to help decide what is best for the patient and everyone who is involved.

> *"I think in medicine there is always the question that doctors always… a lot of doctors always wonder: 'Am I doing the right thing?'… So, you should try to involve local people in ethics teaching because they know the environment, they know the culture in which ethics take place and good ethics is not like 'universal' good ethics; good ethics is because it is in the context in where the people work, and the patients are treated." (T010)*

Another Dutch teacher mentioned that students should be prepared for their future work as medical doctors who will be dealing with people from different backgrounds. He continued by sharing one of his concerns, as well as a challenge, for ethics education in the Netherlands, that medical students might have some difficulty in understanding people with another background.

> *"It (ethics education) gives them also a context… and it's also (important), I think, to make clear to students that their future work, whether it is biomedical sciences or medical, is part of a larger society that has norms and values to live together as good as possible; and you cannot detach their future job from that." (T013)*

In the Indonesian setting, teachers not only expect students to be able to blend into society, but further to have a sense of social responsibility and contribute to society. One teacher spoke about a doctor who built a humanitarian ship for people in the remote islands who have limited access to healthcare, so she felt deeply touched when one of her students decided to work in a remote area in Sumatra prone to earthquakes.

She hoped that it was one of the results of their bioethics teaching, where they shared the motto 'Doctors for the Nation' with students before each class.

> *"First semester (we focus on): academic integrity, then ethics, humanity, law, human rights, and finally the awareness (to give something for our country) … So, when we enter the class, we say: Who are we? (And students reply) Doctors for the Nation!" (G004)*

Like many other Indonesian teachers, one teacher shared her deep concerns about the current situations in the medical training and healthcare system in the country that are far from ideal, and which students will face later as future doctors.

> *"Students are taught the ideal things, but when they enter the hospital/clinical phase… (sighing and shaking her head sadly) … But of course (there is still hope) … Otherwise, what's the point of our fight/struggle?" (T009)*

For Indonesian teachers, teaching ethics is part of a struggle, to fight for social justice and call upon students to stand up for patients' rights, as well as healthcare workers, in a still-developing healthcare system. They expect students to maintain local wisdom and cultural values, as opposed to simply following western textbooks. This sentiment seems to be part of the nationalist view expressed by many Indonesian teachers in our study who felt that the current medical ethics education is very much influenced by western values.

Table 3a. Non-similar goals of medical ethics perceived by Dutch teachers

Categories	Codes
Understanding one-self	Self-reflection
	Personal identity
	Aware of own values
	Question own behaviour
	Aware of different roles
	Discuss feelings and emotions
Learning from others	Share experiences
	Open for discussion
	Be in dialogue with others
	Be able to explain to others
	Understanding other people

Different goals

We found four other goals that differed between the two countries, with two from each setting. Tables 3(a, b). Many Dutch teachers emphasized the importance of understanding one-self and learning from others as being some of their main goals, while Indonesian teachers discussed the importance of religion and keeping one's faith and piety, as well as obeying rules and understanding the law, as important goals in ethics education.

Table 3b. Non-similar goals of medical ethics perceived by Indonesian teachers

Categories	Codes
Being faithful and pious	Religious values
	Religious behaviour
	Blessing for others
	Noble professionalism
	Being faithful and pious
Following rules/standards	Medico-legal
	Obey the law
	Obeying rules
	Code of ethics
	Aware of regulations

1. Understanding one-self

This category was often emphasized by Dutch teachers and hardly mentioned by Indonesian teachers. Dutch teachers expected students to be able to self-reflect and to be aware of their own values. This includes discussing feelings and emotions and being able to question their own behaviour. One teacher described how she triggers students during small group discussions to reflect on their own thoughts and values in order to understand themselves.

> *"My goal is that they understand themselves, that they reflect on themselves also. I try to give back to what they say: 'So this is what you're saying . . . umm . . . what does this mean? What do you think about it?' So, they examine their own thoughts." (T003)*

Another teacher described that ethics is an experiential knowledge that involves both cognitive and affective aspects, namely feelings and attitudes. He stated that it is not easy to reason from a totally neutral perspective because one becomes more or less emotionally involved when they think about ethical problems, even if they did not

experience the cases themselves. He suggested that getting 'involved' deeper into an ethical case might be useful to develop one's moral reasoning.

> *"Let me make it more practical. For me, it means that you always need to spend time on how it feels for you in the situation. How do you feel involved? What do you feel about people doing this or that . . . And that's not the end point for the moral reflection, but as a starting point, because you can never do without it." (T006)*

2. Learning from others

One teacher (T006) discussed further that there are two end goals of ethics teaching. The first is to have moral sensitivity, and second is to know what we should do and should not do. He explained that moral sensitivity can only be developed when we interact and are involved with people, and when we are open and willing to see that morals and values could be viewed differently by others. This view was also shared by other Dutch teachers who mentioned about learning from others as an important goal in ethics teaching.

> *"It's about group interaction… try to see if they can learn from each other. 'Okay, I hear you say this, but you (another student) say something different. Okay, what's the difference?' It's important that you can acknowledge why you found a connection on what you agree on, but also acknowledge the difference… 'Okay, what is at stake for you in this situation, why do you find that so important?' Or: 'what is under pressure here that you become so angry with it?' And make that (the values) explicit." (T006)*

From the interviews, we can see that the two goals (understanding oneself and learning from others) are closely related and intertwined, and they were strongly emphasized by Dutch teachers. Although Indonesian teachers mentioned 'different perspectives', which might be closely related to 'learning from others', it was mainly used in referring to solving ethical problems as the main goal.

3. Being faithful and pious

This category was often emphasized by Indonesian teachers and hardly mentioned by the Dutch. One Indonesian teacher who teaches ethics in an Islamic University emphasized the role of religion and its position in ethics education. She explains that religion should be a basis for everyone to be able to have an ethical mindset. Furthermore, like religion, ethics should be a 'blessing for all', not only for an individual

or a single group of people. Therefore, religious values are embedded within the ethics curriculum and often become an important reference during ethics discussion.

> *"If we practice our religion correctly/properly, then our ethical reasoning should work; it's not the other way around . . . ethics should be a blessing (Bahasa Indonesia: 'rahmat') for everyone, not only for oneself." (G006)*

Another Indonesian teacher also stated that ethics teaching, in her position at a medical school in an Islamic University, is very much related to religion, not only to Islamic values but also other religions. One of the goals is to be able to perform *'muhasabah'*, a form of religious reflection and self-evaluation in Islam, leading to acts of avoiding evil and doing good. During clerkship, medical students are required to perform *muhasabah* as a written task, to better prepare themselves in entering each clinical round. This tradition is similar and resembles the purpose of self-reflection in the Dutch context, except that it is done from a religious point of view.

> *"We have a kind of 'self-assessment', more into religion, called 'muhasabah' (self-evaluation), hoping to see that they can do much more positive things towards the end of their clinical rounds." (G016)*

Interestingly, this view on religious values as an important part of ethics education was not only shared by teachers who were based in religious universities, but also by teachers who worked in public universities in Indonesia. Some teachers stated that ethics teaching is often too much oriented to western values, which does not fit well with the cultural and religious values in Indonesia. They believe that ethical and religious values should not be separated and therefore they instilled religious values within their teaching.

4. Following rules/standards

Another different category shared by Indonesian teachers was about maintaining an obedient attitude towards following rules and standards, which was considered important as a safeguard to avoid unethical behaviour and practices. One teacher who was a medico-legal specialist suggested that the 'atmosphere' and 'mood' *(Bahasa Indonesia: suasana batin)* of ethics in Indonesia is directed towards issues of malpractice, which is the main source and a common implication of most ethical problems in the country.

> *"In reality, almost all ethical problems eventually become legal problems because that is the atmosphere here… there are lots of malpractice." (G014)*

Another teacher said that, proportionally, the need for legal competence (understanding the law and regulations) should be minimum for medical students. However, she stated that in Indonesia this might be a basic need and therefore a basic competence, because it is more concrete and easier to grasp than ethics. Ethics is considered more abstract and might entail different perceptions. She explained further that it is easier if people are given rules first, and once they get used to them, they would come to realize that it is necessary to be obedient to these rules and would obey them.

> *"For the Indonesian context, medico-legal should be the basic (need) because it's more concrete; there should be strict rules first before ethics. Once they realize that they need the rules, then regardless of being watched or not, people will not break the rules." (G006)*

Indonesian teachers generally consider this crucial, especially in complying to the country's health law and its medical code of ethics to prevent students, as future doctors, from falling into ethical and legal misconducts, which they considered are prevalent in the country.

Discussion

Similar goals: global or local?

Teachers from both countries shared three similar goals, two of which are mentioned in the respective frameworks: to be a professional doctor and to be able to deal with ethical problems [1,2]. Previous studies suggest that these are indeed the two main goals or views of ethics education shared in many countries [16,17]. However, there were slight differences in our study concerning what teachers consider as being professional. Dutch teachers emphasized professional integrity and how students, as future doctors, should be critical of their own profession. For Indonesian teachers, professionalism emphasized more on how to behave professionally and how to communicate with patients and families. Hence, Indonesian teachers are concerned about how students can perform or demonstrate their professional behaviour, whereas Dutch teachers are more concerned about how students can develop their own ethical understanding and inner sense of professionalism. On dealing with ethical problems, Indonesian teachers consider the four basic moral principles [18] as an important set of standards to solve ethical problems. This is also evident from the questions that appear in the national examination for medical students on the subject of medical ethics, where ethical

questions often refer to these basic principles using multiple choices with one single best answer. Hence, it is common in Indonesia to find students in ethics classes asking what the right answer or best solution is to an ethical problem. Dutch teachers, on the contrary, are quite hesitant to use the word 'solve', because they suggest that ethical problems cannot be solved in the same way clinical problems are solved. Moreover, Dutch ethics teachers want students to learn and accept that not all problems can be solved and that students should learn to cope with the ethical problems they encounter.

The third similar goal is being part of society, which is rarely discussed in previous literature concerning medical ethics education. This is interesting, considering that the UNESCO's bioethics core curriculum proposes 15 principles based on the Universal Declaration on Bioethics and Human Rights (UDBHR) [19], in which the last six essentially underscore the importance of being part of society, including solidarity and social responsibility (UDBHR articles 12–17). A recent study conducted by Torda and Mangos [20] in Australian and New Zealand medical schools also showed that besides the two main goals, namely ethical knowledge and reasoning, and attitudinal or behavioural development, other specific goals were mentioned, including notions of social justice. In future discussions in medical schools, it may be possible to consider not only cases concerning the patient-doctor relationship, but also concerning the doctor's responsibility to the society as a whole. This possibility can serve as a starting point to include social justice as part of the goals of medical ethics education in a globalized yet struggling world with social disparities and inequalities in many parts of the world.

Different goals: acceptable or problematic?

The importance of reflection in ethics education has been discussed in previous literature [21,22] and appears as one of the main goals of ethics education in the Netherlands and in other western countries [23,24]. Dutch teachers in our study often mentioned reflection, as part of understanding one-self and understanding others, as an important goal in medical ethics. In the Indonesian context, reflection was very rarely mentioned, and it was referred to in the context of contemplation or self-evaluation from a religious point of view. Hence, ethical reflection seems to be one of the main differences in the learning goals between the two countries, where it is common in the Dutch setting and less common in the Indonesian contexts.

Previous literature suggested that in many Asian countries, culture and religion remain important aspects in medical ethics education [25,26]. Although culture and religion (beliefs) were often discussed during ethics classes in the Netherlands, they are not embedded within the medical curricula as such in Indonesia. We found that the perceived goals from the perspectives of Indonesian teachers in our study appear to be in line with the first area of competence of the medical training framework, namely 'noble professionalism', which serves as the basic foundation for medical education in the country [2]. Competencies under this area include: (1) Belief in God, (2) Moral, ethical and discipline, (3) Awareness and obedience to the law, (4) Social and cultural insight, and (5) Behave professionally. Hence, these ethics competencies appear to be clearly defined in the Indonesian framework. Moreover, being pious and obeying the law are two goals that differ between the two countries in our study and are unique for Indonesia.

In the Dutch context, ethics competencies are deduced or translated from all of the CanMEDS competence domains, namely: medical expert, communicator, collaborator, leader, health advocate, scholar, and professional [1]. Unlike the Indonesian framework, the ethics competencies in the Dutch framework are spread throughout the seven domains and there is more flexibility and freedom to interpret the competencies. Although Dutch teachers mentioned health law as an important source of knowledge for medical students, it is not part of the goals of ethics teaching as it is in Indonesia, even though they are often related and intertwined when discussing ethical cases [27]. In the Netherlands, teachings of ethics and law are often organized separately for practical reasons, unlike the UK, where teaching and learning of medical ethics, law and professionalism are integrated throughout the medical curricula [28].

The question arises if such differences in learning goals also occur in other countries and regions and what this means for the global audience regarding medical ethics teaching. Unlike previous studies conducted in the USA and European countries, where many similarities were found [29,30], a study by Miyasaka suggested that medical ethics teachings in the Asian region are more diverse, not only regarding the organization of the teaching programs, but also regarding its content. The differences were reflected by the historical and sociocultural contexts of the medical schools in the respective countries [31]. Other studies suggested that cultural differences are a substantial factor

and have a strong impact in perceptions of ethical attitudes and ethical decision-making [32,33]. Considering the strong influence and relationship of culture and ethics [34,35], it would be logical and sensible to understand that ethics is both global and local. Ethical values and principles may be universal, but many of them are perceived and practiced differently according to the local cultural context. Therefore, we argue that differences in learning goals in ethics education worldwide is simply fair and common. It is an existing situation that is 'a given' or a reality, which we need to deal with wisely and thoughtfully.

Students as well as doctors and health care workers nowadays can easily communicate, thus making lectures and discussions easily accessible to a wider range of audience across borders and regions. However, discussing ethics with peers and colleagues across regions carries a risk of a 'clash of culture' or 'clash of values'. Introducing and discussing major differences in learning goals, such as the importance of reflection and emotion in the Dutch setting and the importance of religious values in the Indonesian, to a global audience can be challenging. The bigger challenge, however, might be to learn and understand the subtle differences within the similar or 'universal' goals, such as in defining professionalism. For instance, being professional in the Dutch context might not be considered the same in the Indonesian setting, and vice versa. From our experiences in Indonesia, and as shown in the results of our study, learning ethical principles and values from a western perspective carries the risks of misperception, if not out-right rejection, from some teachers. However, this backlash or reaction should not hinder or become an obstacle for ethics teachers from different parts of the globe to come together and engage in discussion. We believe that being connected means creating more learning opportunities, to get to know and learn from each other, and not necessarily having to adopt or incorporate those differences into the local context.

Strengths and limitations

The sample size for the Indonesian setting is relatively small compared to the Netherlands, which only has less than one tenth the number of medical schools in Indonesia (8 compared to 86 schools in 2018). Indonesian participants in our study mainly came from Java and only a few participants were from Sumatra, Kalimantan, and Sulawesi. Hence, we could have recruited a more diverse respondent population, although one third of all medical schools in Indonesia are located on the island of Java.

Some translations from Bahasa Indonesia to English might have slightly different meanings and perceived differently by non-Indonesian readers, although forward and backward translations were carefully done. To our knowledge, our study is the first to explore this topic in the respective countries and to make a comparison between the two.

Conclusions

Our study suggests that despite the similar goals in medical ethics shared globally, there might be differences in how teachers in different cultural contexts perceive the goals with their local values and how they translate the goals into the learning process. We believe that differences in learning goals are fair and natural, and therefore should not become a barrier for teachers among different countries and regions to communicate and collaborate for the development of medical ethics education. Understanding differences in learning goals, as well as differences in perceiving ethical values, could be an important goal for ethics teachers worldwide to broaden their knowledge and perspectives.

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Ethics approval and consent to participate

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Chapter 5

"I WOULD DO SOMETHING IF I COULD!"

EXPERIENCES AND REFLECTIONS FROM ETHICS TEACHERS ON HOW TO RESPOND WHEN HEARING ALARMING CASES FROM MEDICAL STUDENTS

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Abstract

Background: Previous studies show that teachers can feel disturbed by alarming cases brought up by students during their teaching activities. Teachers may feel uncertain about how to deal with these cases, as they might feel responsible to take action to prevent further harm. This study aims to explore how ethics teachers in medical schools would respond to a student report of unethical or unprofessional behaviour during the clinical training phase (clerkship) that is alarming and potentially harmful for patients or students themselves.

Methods: This study used qualitative methods with purposive sampling. We conducted in-depth interviews with 17 teachers from 10 medical schools in Indonesia. We asked if they had heard any alarming and harmful cases from students and provided two cases as examples.

Results: Four teachers shared their own cases, which they perceived as disturbing and alarming. The cases included power abuse, fraud and deception, violation of patient's rights and autonomy, and sexual harassment. Regarding teachers' responses in general, we found three main themes: (1) being assertive, (2) being careful, (3) barriers and facilitators. Most teachers were convinced of the need to take action despite numerous barriers, which they identified, leading to doubts and concerns in taking action. Our study shows that formal education in ethics might not necessarily influence how teachers respond to alarming cases, and that their responses are mainly influenced by how they perceive their role and responsibility as teachers.

Conclusions: Our study suggests that teachers should carefully consider the risks and consequences before taking action upon alarming cases to prevent further harm, and that support from higher authorities might be crucial, especially in the Indonesian context. Our study also shows that taking action as a group might be appropriate in certain cases, while personal approaches might be more appropriate in other cases. Most importantly, school leaders and administrators should develop effective organisational culture and support students and teachers for their ethical responsibility commitment.

Keywords: *ethics teachers, medical students, clinical clerkship, alarming cases, student reports, student disclosur*

Background

Teachers in medical schools often hear reports of ethical problems and unethical practices in training sites. These reports may come from students or colleagues through formal or informal communications or mechanisms. In places where ethical case discussion is used as one of the teaching strategies, students sometimes present alarming cases that are potentially harmful for patients, healthcare workers, or students themselves. These may include breaches in medical ethics as well as unethical behaviour of healthcare workers towards patients and students. Previous studies show that both students and teachers can feel emotionally disturbed by ethical problems. Students often observe or encounter ethical issues or ethical dilemmas during their clinical training in the hospital and often experience moral distress [1–3]. Teachers, on the other hand, sometimes feel disturbed and uncertain about how to deal with cases that are brought up by students during their teaching classes [4]. Teachers may face a dilemma of weighing between the safety of patients in one hand and keeping the privacy and confidentiality of students on the other. As ethics teachers, they might also have limited authority to handle such cases. The development of systems to respond to student disclosures may vary among institutions. In some medical schools in Indonesia, for instance, there is a counselling unit that provides consultation for students who have academic problems. Teachers may also refer students to such unit if they feel the student is in need of psychological support. However, the counselling unit might have limited authority to deal further with cases involving potential ethical and professional misconducts in the hospital.

Medical ethics teaching is not something new in Indonesia. For decades, medical ethics *(Bahasa Indonesia: etika kedokteran)* has been a mandatory subject in all medical schools. However, lectures in ethics were often limited to introducing the Indonesian Medical Code of Ethics or KODEKI *(Kode Etik Kedokteran Indonesia)*, and occasionally, some existing law or regulations in health care. Lectures were usually given by senior professors, mainly medical specialists, without any formal background in ethics, although some might have had formal training in law or medicolegal. The lectures may have included examples of 'ethical violations', namely breaches or violations of the medical code of ethics or health law. However, in-depth discussions in class were rarely carried out. This condition was perhaps due to the limited time

allocated within the medical curriculum and the previous learning methods in general, which did not have much room for discussions. Unlike medical ethics in this sense, bioethics is a new emerging field in the country; even though both share the same concept of addressing ethical issues in (bio)medicine and health care. For the Indonesian medical community, bioethics, which was widely introduced around the year 2000 in national conferences [5], has brought forward the idea of ethical dilemmas and ethical principles, thus opened space for ethical discussions within the medical curricula. In 2006, a new standard of competencies for physicians was introduced [6] along with a so-called competence-based curriculum (KBK) model and problem-based learning (PBL) method. Since then, medical schools have established competency-based curricula and adopted the PBL method, which provided more room for in-depth ethical case discussions in large or small groups.

This paper demonstrates how ethics teachers in medical schools in Indonesia reflect on how to respond when they find out about alarming and potentially harmful cases from students during teaching. Our study aims to explore how teachers in medical ethics would respond to a student report of unethical or unprofessional behaviour during the clinical training phase (clerkship) that is potentially harmful for patients or students themselves. Knowing teachers' responses, we will be able to identify what can and what cannot be expected from them and what kind of support is needed, especially regarding their positions as ethics teachers in an academic hospital. For this purpose, we conducted a qualitative study to explore what kind of alarming cases were brought up by students, teachers' initial responses, and how they reasoned and reflected on their decisions. This study is part of a larger study on ethics education in medical schools during the clinical training phase (clerkship) in Indonesia and The Netherlands.

Methods

This qualitative study used purposive sampling and thematic analysis. In 2018, there were 86 medical schools (36 public, 50 private), with one third located in Java [7]. However, information on the total number of ethics teachers from all medical schools was not available. Therefore, we first identified teachers who were actively involved in the development of bioethics and who have participated in bioethics meetings and training courses in Indonesia. We selected 25 potential participants, starting with teachers from leading medical schools that might have had ethics teaching in the

clerkship phase. We then invited a diverse sample across teaching sites: both public and private universities, more recent medical schools, and diverse demographic characteristics, including age, gender, and educational background. We obtained teachers' phone numbers and invited them through text messages, explaining the purpose of the study briefly and inviting them for an in-depth interview.

Upon their agreement, we sent the information sheet and consent forms through e-mail. All teachers who were invited agreed to participate, but one participant eventually cancelled the interview due to other obligations. Due to the relatively small number of teachers working in this field, most participants were already familiar with the researcher professionally. The researcher's professional backgrounds and experience in ethics teaching were most valuable in building rapport and gaining trust from participants. We believe that good rapport between the researcher and participants is essential for this study, considering sensitive matters that may come up during the interview.

The interviews were conducted at participants' respective workplaces, except for one participant who preferred to be interviewed outside of her workplace. Three interviews were conducted by telephone due to the long distances. Permission to record the interview and take field notes was obtained. All data were kept anonymous and unidentifiable to ensure the teachers' and students', as well as the patients' privacy and confidentiality. In-depth interviews were conducted by AM, RBW and DL in Bahasa Indonesia and transcribed verbatim. Transcripts were de-identified, meaning no personal identities and other potentially identifying information were written in the transcripts. Coding was done manually by AM and RBW, using excel sheets and tables. Initial codes were generated from teachers' responses of alarming cases, how they reasoned and reflected on their decisions, and grouped into potential themes and subthemes. Themes were checked against each other and back to the original data set. Potential themes and subthemes, as well as naming of the main themes, were reviewed and discussed together with MH, DW, and AU (who did not conduct the interviews and did not know the respondents) until consensus was reached [8]. Data saturation was reached after 15 interviews, and two additional interviews were conducted to make sure no new themes emerged, adding up to 17 participants in total [9, 10]. The interviews' duration ranged from 38 to 126 min, with an average of 80 min per

interview. AM and RBW are medical doctors and teachers in medical ethics in Indonesia, while MH and DW are teachers in medical ethics in the Netherlands. AU is a medical doctor, professor of research methodology and qualitative methods in Indonesia, and is not involved in ethics teaching. The mixed team members from Indonesia and the Netherlands, with professional backgrounds and experience in both medical training and ethics teaching, were most valuable in the process of data analysis, in being able to relate well to the issues, in sharing insights and perspectives, and adding reflexivity to the process [10, 11].

We first asked participants if they had any experience in ethics teaching in the clerkship phase, and if they had, during their teaching activities, heard any cases from students which they thought were alarming and harmful. We then asked how they responded, if they had done any action outside the classroom, and asked their reasoning. We were interested in teachers' personal responses and actions to any actual, reported or theoretical, student disclosures of alarming behaviours. Hence, we provided two cases from our previous studies as theoretical examples in case they were not involved in ethics teaching in the clerkship phase. The first case was about a student who was told to cover up mistakes in the operation room; the second was about a student who was asked to conduct physical examination of an intimate area on unconscious patients without consent beforehand for teaching purposes. We have chosen the two cases for two reasons. First, both cases presented potential harm and involved vulnerable patients, fraud, and deception. Second, both cases were considered disturbing in previous studies elsewhere [3, 4, 12]. We asked them what they thought if they were the teachers who received the cases, explored further if there were any actions they would have done, and asked their arguments. Interpretations of transcripts, including the English translations, were sent to participants through e-mail to ensure their own meanings and perspectives are correctly represented [13–15]. Two participants suggested minor corrections of translation, and one participant did not respond. No repeat interviews were carried out.

Results

Teachers' characteristics Seventeen teachers from ten medical schools in Sumatera, Java, and Sulawesi participated in our study. Fifteen participants were professionally trained as medical doctors, either with or without additional speciality (referred here as 'medical specialist' and 'general practitioner'). Most participants also had additional training (master and/or doctoral) in one or two of the following disciplines: medico-legal, ethics, philosophy, or medical education. Only two participants were not medical doctors and had formal educations in philosophy and ethics (Table 1).

Table 1. Teachers' characteristics

Characteristics		Number
Sex	Female	8
	Male	9
Home base university	Public	12
	Private	5
Experience in ethics teaching	<5 years	5
	5-10 years	5
	>10 years	7
Professional background	Medical Doctor	15
	(Medical specialist)	(9)
	(General practitioner)	(6)
	Non-Medical Doctor	2
Additional master/doctoral degree	Medico-legal	6
	Ethics	3
	Philosophy	3
	Medical education	3

Teachers' stories

When asked if they had any experience in ethics teaching in the clerkship phase, only five (out of ten) medical schools in our study had some form of structured ethics teaching in the clerkship phase, and four (out of seventeen) teachers experienced receiving cases from students during their teaching activities. Hence, not all teachers were given the two examples of alarming cases (see Methods, third paragraph), as they had shared their own cases that had happened repeatedly and were considered potentially harmful and alarming. The alarming cases shared by those four teachers in our study included abuse of power, fraud and deception, violation of patient's rights

and autonomy, and sexual harassment. Below are two cases in which teachers took action, yet in a different way. The teachers shared their opinions about the outcome, what went well and what could have been done differently.

Taking advantage from students

One of the teachers shared a case from her colleague about a student who felt uncomfortable working at one of the clinical departments because one specialist sometimes asks students to do things that were not part of their tasks.

> *"The student said that the doctor sometimes asked students to take him somewhere, buy some food, or pick up his kids. They were also told to work at a hospital they had no MoU with. When we tried to investigate further, another student mentioned: 'Well, 200 or 300 thousand rupiahs might mean a little to others, but it means a lot for us because we have to pay'." (G016)*

The case became a heated topic because the teacher immediately reported the case through a social media group for teachers mentioning the student's name. The case was reported further by the head of the medical program to the head of the clinical department and the dean. The doctor was then identified and questioned by the authorities: *"What have you done, telling students to do things that are not part of their job?"* The doctor who was accused said that he felt mistreated and humiliated. Some students said that the doctor should not have been reported because it was common in medical training. After the incident, students became hesitant to share cases and became quiet during discussions due to fear of being reported.

When asked what she thought about the action taken, the teacher said that it would have been better if they had met the doctor in person to confirm the case and remind him in a nice way. They should also not mention any names, including students, to protect one's reputation and not ruin the relationship between teachers and specialists at the hospital. Although some of her colleagues thought differently, saying that it was appropriate to open the case to prevent others from secretly doing such a thing, she disagreed and supported other colleagues who were worried that the specialists would keep a distance and would no longer be willing to supervise students; and that would not be good for the students and the institution.

Asking for extra payment from patients

Another teacher shared a case which he heard from his students during the ethics discussion. The students said that one of the doctors in the hospital charges extra payment from patients. He was shocked and thought that it was a crime to do such a thing.

> *"There is this doctor who charges extra payment from patients, where in fact the cost should be paid to the hospital administration. When the student asked the doctor (the doctor replied): 'This is my USG (Ultrasonography) device, it does not belong to the hospital'. Students did not consider it as unethical but unprofessional, and some even said it's a crime. I think it is a crime." (G007)*

Table 2. Actual actions taken

Participants	Alarming cases	Actions
G001	Disrespectful to patients and violation of patients' rights	Investigate further Personal approach
G007	Fraud and falsification of financial reports	Investigate further Pass information to the higher authority Collaborate with other units/departments Educate doctors through workshops/seminars
	Sexual harassment to medical students	Investigate further Pass information to the higher authority Personal approach
G015	Deception and violation of patients' rights	Investigate further Collaborate with other units/departments
	Misconception leading to breaches in medical ethics	Conduct more extensive study/research Educate doctors through workshops/seminars
G016	Abuse of power to medical students	Pass information to the higher authority Discuss openly in departmental forum/meeting

He decided to collect more data and discovered that similar cases had happened. Together with colleagues who were in charge for the clerkship program, he reported the case to the higher authorities at the faculty level, who then conducted further investigation in the hospital. They believed that the case needed to be dealt with carefully, so an in-house training for all doctors was organised to protect the anonymity of the doctors involved. The case was re-written as if it happened elsewhere with a

different nuance. The organisers also ensured that participants could identify or relate to the case and let them know what the authorities and ethics team thought about it. Participants then responded by mentioning that they had done similar things in their practice.

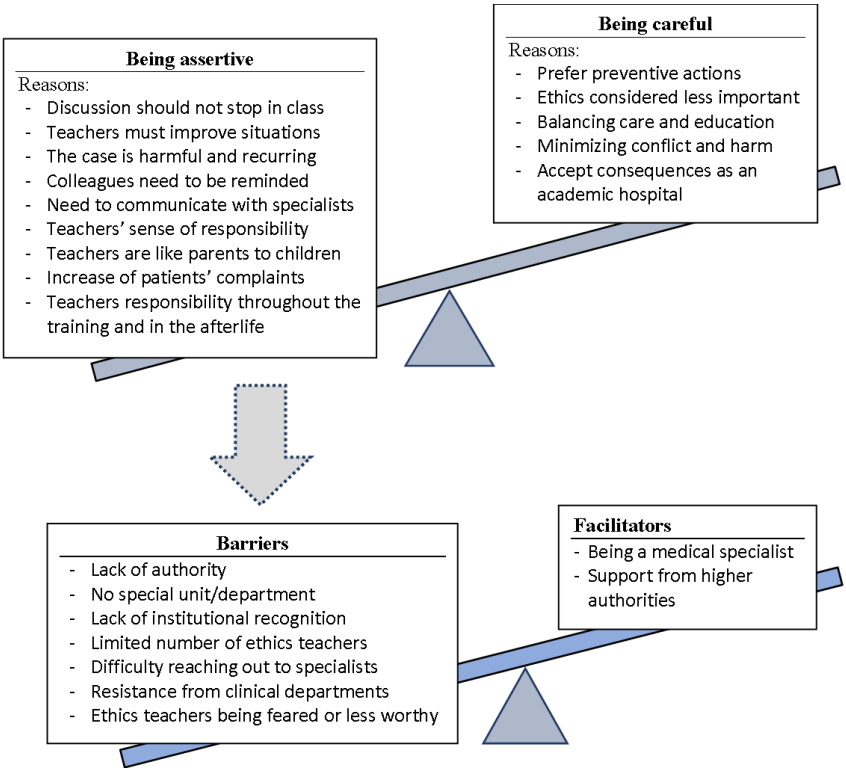

Fig. 1. Teachers' responses

The teacher said that he was happy with his action because when they discussed the issue together, the doctors became aware that it was unethical to do such a thing, mostly because they sometimes had to falsify certain documents. This issue includes cases of double insurance, where they had to falsify documents based on the patient's request. The teacher thought it was good if doctors could have such discussions and have some 'mutual awareness' about ethical problems. Through teachers' narratives, we identified

actual actions taken in various steps and forms (Table 2). These actions were taken outside of class, namely outside of students' learning environment and learning process.

Teachers' responses

We explored responses from all seventeen participants in our study, even though only four teachers had their own cases from students' reports. For the other teachers who did not have any cases from students' reports, we provided the two alarming cases from our previous study. Although most of the teachers (14 out of 17) in our study were convinced of the need to take action when hearing alarming cases, they all shared concerns about doing so after reflecting and identifying the barriers which were more prevalent within the training system compared to the facilitators. We came up with three main themes: [1] being assertive, [2] being careful, [3] barriers and facilitators (Fig. 1).

Being assertive

Most of the teachers in our study were quite assertive in saying that further action should be taken when it comes to patients' and students' safety and well-being. Below are responses from two lecturers who had reasons to believe that action should be taken. The first lecturer, who was a general practitioner and relatively junior in terms of age and teaching experience, received a case about a doctor who blamed a patient in front of other patients for refusing treatment, pointing out that she was covered by the national health insurance, namely BPJS/JKN *(Jaminan Kesehatan Nasional)*, meaning that she was poor and that she should just follow the doctor's suggestion. The teacher felt disturbed by the fact that the doctor associated the JKN with poor people and that they were supposed to have less autonomy. She felt concerned that this false perception would spread out to patients and students.

> *"It was really unethical and harmful for patients, so I asked the students to give a clue who the doctor was. It was not only because I was annoyed (Bahasa Indonesia: geregetan), but I felt that I needed to remind that person. I was hoping… if I knew the doctor personally, perhaps I could somehow communicate the problem, maybe indirectly... Perhaps we can discuss it." (G001)*

The teacher wanted to approach the doctor but eventually decided not to, after discovering that she did not know the doctor well enough to discuss the sensitive matter. The second teacher, a senior medical specialist and head of a department, did

not have any case of his own, but he had strong opinions in response to the case examples (see Methods section). The teacher did not hesitate in saying that doctors should be given sanctions to avoid further harm to patients, especially if they had been given some warning before, and there are no improvements. Nevertheless, he suggested that the cases should be first discussed within the clinical departments to avoid open conflicts.

> *"We should talk to the head of the department. That would be the best way, although I have never done it before. If there were such cases, I would do it. If there were, for instance, a resident involved, we have to prevent harm to anyone, including residents. But if we cannot 'fix' them, then what to do, it's harmful to patients! They might even need to be expelled from their work." (G011)*

Among 14 teachers who were convinced of the need to act, almost half (6 teachers) were senior lecturers with more than 15 years of teaching experience (not only ethics in particular), and more than half (8 teachers) were non-specialists. Our study did not find any differences between junior and senior lecturers or between medical specialists and non-medical specialists in their willingness to act upon students' reports of alarming cases.

Being careful

Only three teachers, all medical specialists, were less assertive and more careful in deciding to take action. Below are their responses on the case examples, as they had not received alarming cases from their students. The two case examples were about students who were told to cover up mistakes and asked to conduct physical examination of intimate areas on unconscious patients. They viewed the cases as rather dilemmatic situations in clinical training, and emphasised the need to carefully balance the values, risks, and consequences to avoid further harm to students, patients, and doctors.

> *"It is dilemmatic. I think we need to analyse it further because I don't know... How is it actually from an ethical perspective? If it is not considered right, then clinicians should be informed. Maybe they are not fully aware and just want to educate students." (G013)*

> *"I cannot blame nor justify anyone. How can they (students) have clinical skills if they do not examine patients? We must introduce them, and many patients might refuse, so maybe that is the dilemma. If all patients refuse, then what will happen to our students?" (G010)*

> *"It is a win-win solution because the learning process needs to go on. For those (students) who feel it conflicts with their conscience, then they should not do it,*

but they should not get punished (for not following orders). But if they are willing to follow, then they may." (G014)

One explanation that may be generated from the interviews and the quotes above was that medical specialists had experienced the complicated situation of being a clinical teacher in the hospital with dual responsibility towards patients and towards students. This complexity might explain why they were more careful in balancing between what is best for their patients and what is best for students' learning experience.

Barriers and facilitators

In our study, teachers identified different barriers and facilitators, despite their strong willingness and intentions to act upon hearing the alarming cases. Two main facilitators for taking (or *suggesting to take*) action were: [1] being a medical specialist (clinician) and [2] support from higher authorities (see Fig. 1: Facilitators, and Table 3). The latter was considered most effective in implementing actions, although being a specialist was considered more influential in promoting ethics and spreading the knowledge among other specialists in the hospital.

Table 3. Facilitators to take action

Coding	Quotations
Being a medical specialist	*"So, the clinicians… when they see you (as a general practitioner), they would say: 'you're not a clinician, so why do you say such things?' But if I (as a clinician) say it, then they will be surprised!" (G010)*
Support from higher authorities	*"I think the best way for medical schools in Indonesia is a top-down approach. I think what I did previously with the bottom-up approach was quite aggressive, but if there is no structure (authority), then it's not convincing…" (G017)*

Nevertheless, the majority of teachers shared similar concerns and barriers for the overall situation of ethics teaching in medical schools, in the clerkship phase in particular (see Fig. 1: Barriers), especially the difficulty to reach out to their colleagues in the clinical departments (referred to as "specialists" or "clinicians"). Other barriers include having less authority, the limited number of ethics teachers, and lack of institutional recognition (Table 4).

These barriers were mentioned by most teachers in our study. Moreover, we did not find any major differences among groups of teachers, i.e. between teachers with different educational backgrounds, between medical specialists and non-medical specialists, or between junior and senior lecturers. In Table 4, three of the respondents were senior medical specialists with high positions within their respective institutions, who presumably would have had more authority compared to other teachers. Nevertheless, they shared and identified similar concerns and barriers with regard to ethics teaching in the clinical clerkship phase.

Table 4. Barriers to taking action

Coding	Quotations
Difficulty reaching out to specialists	*"I think it's difficult… rather impossible in the medical culture. It's an institutional problem. It is strange, indeed, this relationship (between non-specialists and specialists). The specialists sometimes don't think of themselves as teachers." (G003)*
Resistance from clinical departments	*"Maybe because they (clinicians) are old, so they have a different way of thinking. And the problem is that many of them do not like ethics; so (they would say) 'why should we bother with such thing?' I think." (G010)*
Being feared or less worthy	*"Well, I would (do something) if I could! But the problem is… I'm not sure, maybe this is just a coincidence, but I think I'm not a likeable figure here… maybe they are afraid of me, or just reluctant, I don't know…" (G014)*
Difficulty reaching out to specialists Resistance from clinical departments	*"We need to remind the students, that is most important! Ask them what they think about it. But If we want to intervene in the (clinical) departments, it would be very difficult, because as you know, they are like these 'kings in small kingdoms', right?" (G015)*
Lack of authority Limited number of staffs Lack of institutional recognition	*"I think I cannot do it alone. I was no longer head of the bioethics team, so I have to say that the case was rather neglected because I need a partner to work with, someone who is also interested in ethics. At this moment, we only have six people in this department (which is not an ethics department), each with a different specialisation… If there are not any separate body/unit and at least 1-2 people focused on ethics, then it becomes difficult" (G017)*

Discussion

Being assertive: responsibility as teachers

The majority of teachers in our study were assertive in responding to both actual and hypothetical student disclosures of alarming cases. In Indonesia, teachers view their

tasks as to transfer knowledge and skills, and guide students throughout their education. Teachers are not only responsible for students, but also responsible to the parents, nation, and religion [16, 17]. Although teachers in our study are classified as 'lecturers' (Bahasa Indonesia: *dosen*), they perceive their role and responsibility as 'teachers' (Bahasa Indonesia: *guru*). The law states that both teachers and lecturers should commit to promoting faith, piety, and noble character [18]. This role is supported by the Standard of Competencies for Indonesian Physicians (SKDI), placing "Noble Professionalism" as the first and basic area of competence, which includes belief in God, ethics, and discipline [19]. Teachers' responses in our study reflect this view, saying that they are responsible for students, as parents to children, throughout their training and until the afterlife. This view might explain why teachers' initial responses were quite assertive in taking action, considering the barriers they were aware of. However, our findings might also suggest how ethics teachers in general respond to reports of alarming cases from colleagues or students outside of their teaching activities. Moreover, clinical educators who are not involved in ethics teaching might also have similar responses when hearing alarming cases from students.

Indonesia is experiencing a transition in medical education and health care. Ethical issues in medical training and health care practices are often related to violations of the country's medical code of ethics (KODEKI). Indonesia's journal of medical ethics, namely *Jurnal Etika Kedokteran Indonesia (JEKI)*, published by the Medical Ethics Honorary Board (MKEK) of the Indonesian Medical Association (IDI) and launched in 2017, is nuanced with topics and discussions of malpractice and ethical misconducts [20–22]. According to MKEK, Indonesia has experienced the so-called "malpractice fever", where there were 122 cases reported within two consecutive years (2004–2005), with at least one-third involving suspects of malpractice, medical error, and legal disputes between doctors, as well as between doctors and hospitals and other professions. Since then, their work and focus has been on professionalism, including ethics and law, to regulate and enhance professionalism of Indonesian doctors with a so-called "ethicolegal" system [23]. Moreover, Indonesia has recently implemented its national health insurance (JKN), dealing with problems of inequity and social justice, and an increasing number of complaints from both patients and healthcare workers [24]. In our study, teachers shared deep concerns, implying a burden and struggle in teaching ethics to future medical doctors in a rather complex and intrusive system.

However, they showed enthusiasm in fighting for the rights of patients, as well as students and physicians. Perhaps we can understand the willingness of most teachers in our study to take action, despite the noted barriers, in relation to this struggle and the emergence of bioethics as a new field in Indonesia.

Being careful: identifying barriers

The medical profession in Indonesia is considered noble and exclusive and enjoys high social status. Therefore, teachers in a medical school without any medical background may feel intimidated if they are involved in clinical discussions. There is also a gap between general practitioners and medical specialists, although both have medical backgrounds. General practitioners are somehow perceived as having a lower degree and social status within the medical field. Moreover, doctors are trained in a hierarchical and authoritative system, often causing negative emotions and barriers to communicate [25–27]. Among seventeen teachers in our study, nine were medical specialists. In contrast to what the above literature suggests, our specialists also identified numerous barriers and shared reasons and doubts not to take action. This phenomenon is perhaps due to the fact that ethical cases came from the clinical departments, and specialists were aware of the reluctance and resistance from their own colleagues. Another reason could be that medical specialists working in academic hospitals have a dual role and responsibility, as a physician who provides care in the best interest of the patient, and as a teacher who carries the responsibility to educate students and share their knowledge and clinical skills with medical students. Our findings show how they reflected on the complexity of being clinical teachers, balancing between their responsibility to patients and students, as well as dealing with their colleague specialists, resulting in a more careful response. Hence, our study suggests that being a specialist is sometimes not enough to facilitate action, although they are considered to have a large influence in introducing ethics to other specialists.

In Indonesia, not all medical schools have teachers trained in ethics, although ethics is in the curriculum. Medical ethics has often been referred to as the medical code of ethics. Hence, ethical problems are often perceived or related to ethical misconducts and violations of the code of ethics. Therefore, ethics teachers are sometimes feared by other teachers for monitoring or criticising their behaviour. This fear is understandable when ethical problems are related to issues of malpractice and ethical misconduct.

Ethics is also considered less important and therefore has limited time and space within the curriculum. These reasons might explain why ethics teachers sometimes do not feel appreciated by their colleagues for the ethical knowledge they have. Hence, pursuing a career in ethics becomes less appealing, potentially causing the limited number of teachers specialised in ethics. This condition could bring further concerns and consequences, including not being acknowledged, not having an official body/unit, and lack of institutional recognition. We believe that this problem should be resolved to prevent teachers from being discouraged in learning and teaching ethics. In our study, three teachers had formal education in ethics, and the majority have followed some ethics training. However, our study does not show any differences in responses between teachers who have and do not have formal education in ethics. This finding indicates that formal education might not necessarily influence how teachers respond to alarming cases, and that their responses are mainly influenced by how they perceive their role and responsibility as teachers and by the culture and environment in which they work.

Teachers' action: balancing risks and consequences

One of the cases told in our study (see Results: Teachers' stories) describes an individual action taken spontaneously by a teacher who reported the case to the higher authorities. It was somewhat unclear if the incident had any positive outcomes or consequences and caused any changes in the behaviour of the doctor(s). Nevertheless, there were negative consequences for the accused person and other students who had taken the doctor's blame. Fortunately, there were no consequences for the student who reported the case. Previous studies suggest that such individual actions, often associated with whistleblowing, may cause negative consequences [28–30], especially in cultures where group loyalty and harmony are important values [31]. Furthermore, spontaneous actions taken without careful considerations might cause harm, especially for students who are in a vulnerable position within the medical training system. Ciasullo (2017), therefore, suggests that whistleblowing "should be understood as a collective, social, and cultural action rather than an individual initiative" [32]. However, individual actions using personal approaches might be appropriate in certain cases, where professional relationships and closeness become an advantage to discuss sensitive ethical problems openly.

In the second case, careful steps were taken before bringing the case to the higher authorities, and the final action was done together as a group with the authorities. Most importantly, the action was targeted to a group of people and therefore minimising harm to individuals. This case shows that discussing cases and concerns with other teachers might be crucial before deciding to take further action. Furthermore, taking action as a group with shared responsibility might be safer and more 'convincing' for higher authorities to accept, as well as for the targeted people [33]. Although higher authorities were involved in both cases, we learned that it is crucial to carefully consider the final goal and most appropriate way to achieve it while preventing further harm. The downside from this non-direct and multi-level approach is that the process might take more time and bring uncertain results, while the alarming ethical problem remains, thus potentially causing harm to other individuals. Balancing risks and consequences, therefore, becomes crucial in such cases. Our suggestions, however, are based on these two cases. More research on situations in which action was taken is needed to get a clearer picture of what kind of support is needed by teachers in this matter.

Recommendations

Finally, we suggest that in the context of ethics education, it may be useful to set up technical procedures for safe reporting mechanisms for both students and teachers. Medical schools can provide consultation for teachers through independent advisors, or advisory boards, to deal with alarming cases for the sake of patients and students, while maintaining privacy, confidentiality, and protecting all parties from blame and further harm [34]. In the hospital setting, ethics committees perhaps could play a role in facilitating openness about alarming cases. However, these recommendations might differ between institutions and regions in Indonesia and in other countries, taking into account different sociocultural factors and educational systems [35, 36].

Strengths and limitations

The selection of participants was based on our network with individuals and institutions who have collaborated and participated in ethics educational programs in Indonesia, mainly coming from Java, Sumatra, and Sulawesi. There might have been teachers and medical schools elsewhere in Indonesia who have already conducted ethics teaching in the clerkship phase but were not included in our study. Although

back-to-back translations from Bahasa Indonesia to English were carefully done for the quotations and interpretations, some words might have slightly different meanings and be perceived differently by non-Indonesian readers. To our knowledge, there have not been any similar studies regarding this topic in the Indonesian context. Numerous studies have been conducted elsewhere on ethics education and students' experiences in dealing with ethical issues and moral dilemmas. However, they rarely (if not any) discussed teachers' experiences and dilemmas in dealing with students' disclosures of alarming cases. We hope this study can contribute to the development of medical ethics education in Indonesia and in other countries.

Conclusions

Our study provides an insight into how ethics teachers in medical schools in Indonesia reflect and respond to ethical cases that were alarming and potentially harmful. Teachers were assertive and expressed a strong willingness to act. However, teachers also identified numerous barriers from within the educational system and medical profession, causing doubts and concerns to realise their actions. We suggest that medical schools and academic hospitals should facilitate clinical teachers and teachers in ethics to discuss their concerns. Our study also shows that in such a high-context and collective culture, taking action as a group with shared responsibility and targeting groups instead of individuals might be appropriate in certain cases to prevent further harm. However, personal approaches might be necessary in cases where close professional relationships can facilitate an open dialogue and discussion on sensitive matters. Most importantly, school leaders and administrators should develop effective organisational culture and support students and teachers for their ethical responsibility commitment.

Abbreviations

BPJS: *Badan Penyelenggara Jaminan Sosial;* ***JEKI:*** *Jurnal Etika Kedokteran Indonesia;* ***JKN:*** *Jaminan Kesehatan Nasional;* ***KODEKI:*** *Kode Etik Kedokteran Indonesia;* ***MKEK:*** *Majelis Kehormatan Etik Kedokteran;* ***IDI:*** *Ikatan Dokter Indonesia;* ***SKDI:*** *Standar Kompetensi Dokter Indonesia*

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Availability of data and materials

The datasets generated and/or analysed during this study are not publicly available due to privacy and confidentiality reasons but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval was obtained from the Medical and Health Research Ethics Committee (MHREC) of the Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, reference number KE/FK/0322/EC/2018. Written consent was obtained from all participants.

Consent for publication

Written consent for publication of the interview data was obtained from all participants.

Competing interests

The authors declare that they have no competing interests.

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CHAPTER 6

STAYING NEUTRAL OR INTERVENING?

ETHICS TEACHERS' IDEAS ON HOW TO RESPOND TO ALARMING CASES BROUGHT FORWARD BY MEDICAL STUDENTS IN CLASS: A QUALITATIVE STUDY IN THE NETHERLANDS

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Abstract

Ethics teachers are regularly confronted with disturbing cases brought in by medical students in class. These classes are considered confidential, so that everyone can speak freely about their experiences. But what should ethics teachers do when they hear about a situation that they consider to be outright alarming, for example where patients/students' safety is at stake or where systematic power abuse seems to be at hand? Should they remain neutral, or should they step in and intervene? In the Netherlands, as in many other countries, there are no clear guidelines for ethics teachers on how to respond. To get more insight into what teachers themselves think a proper response would be, we interviewed 18 Dutch medical ethics teachers. We found that Dutch ethics teachers will address the issue in class, but that they are overall reluctant to intervene; take action outside the scope of class. This reluctance is partly rooted in the conviction that ethicists should stay neutral and facilitate reflection, instead of telling students or physicians what to do. At the same time, this neutral position seems a difficult place to leave for those teachers who would want to or feel they need to. This has to do with various organizational and institutional constraints tied up with their position. The study invites medical ethics teachers to reflect on these constraints together and think about how to proceed from there. This study seeks to contribute to research on cultural change in medicine and medical students' experiences of moral distress.

Keywords: *moral distress, medical students, ethics teachers, responses, alarming cases, qualitative research*

Introduction

Medical ethics teachers are regularly confronted with disturbing cases brought in by medical students. Especially in the master phase, when interns are asked to share personally observed ethical issues, difficult dilemmas can come by. In small-group ethics classes students learn to morally reflect together and because the cases are grounded in personal experience learning is suggested to take place on a deeper level (Kolb 2014). These meetings are confidential, so that everyone can speak freely about their thoughts and share experiences.

But what should ethics teachers do when they hear about a situation that they consider to be outright alarming, for example where patients/students' safety is at stake or where systematic power abuse seems to be at hand? Should they stay neutral and consider it part of students' learning trajectories? Or are they, in fact, obliged to report the case? Should they guard confidentiality, or should they be able to at least discuss it with colleagues?

In the Netherlands, physicians and nurses have a duty to report incidents (mistakes or unforeseen events in care situations) or calamities (incidents that are harmful for patients), for example through VIM *(Veilig Incidenten Melding- Safe Reporting of Incidents)*, so that health care organizations can learn from them. This can be done anonymously. For medical psychologists and hospital counsellors, confidentiality regulations are in place. But there seem to be no clear guidelines for ethics teachers on how to respond to an alarming case.

This is not necessarily a bad thing; teachers might appreciate the possibilities to react to such situation with contextual sensitivity. But absence of clarity could also undermine the willingness to get involved in addressing an alarming case in the first place. Henriksen and Dayton (2006) did research on organizational silence and hidden threats to patient safety and write that when individuals are in doubt or not so secure about their roles, they are less "likely to transcend individual concerns and speak up regarding higher-order organizational concerns".

So, to get more insight into how ethics teachers perceive their own role in the academic hospital-setting, we wanted to know what teachers themselves think a proper response would look like. We interviewed 18 Dutch medical ethics teachers and asked them if they ever met cases from interns that they felt were alarming, how they responded to them, or think they should have responded, and what reasons they had for doing so. By gathering teachers' experiences and views, we hoped to learn where ethics teachers feel their responsibility for the well-being of students (and patients) begins and ends, how they think they can support students in such a situation, and how they themselves perhaps can be supported in dealing with this type of information.

So where do we draw the boundary between a disturbing and an alarming case? In our study, we constructed the following definition: a case is alarming when the situation described is considered to be so harmful (for a patient, patients' family, student, colleague) or unjust that it appeals to the teacher's personal sense of morality. An alarming case evokes a feeling of disbelief, worry or even outrage in the teacher about the situation described ('I cannot believe I am hearing this!!', 'But something should have been done!'). Such cases make the teacher doubt as how to respond properly - instead of just treating the case as any other. Of course, this experience will vary between teachers and will also change during their teaching career.

Methodology

Six out of eight Dutch academic hospitals offer small-scale classes in which students discuss personally observed ethical cases during the master phase. We limited our study to these six academic hospitals and made sure to interview at least two teachers in each hospital. We mainly spoke to regular staff (assistant and associate professors), because they teach such classes more regularly. But we also talked to three teaching PHD students.

Our goal was to explore the variety of perspectives and experiences present among ethics teachers, so we made a purposive sample. The variety between participants was wide in terms of age (between 22 and 65 years), gender and educational background. About half of the teachers had finished a study in medicine or nursing, before turning to a study in ethics or law. Two of them were practicing physicians (paediatrician and

GP) at the moment of the interview, three had worked earlier as a nurse. The other teachers were trained in philosophy, humanity, psychology or pedagogics. Two of them had experience working as spiritual caregiver.

Participants were approached through email. 18 out of 20 teachers who actually were (or had been) involved in discussing cases from medical students were willing to participate. We obtained permission to have the interview audio recorded and agreed that all data were kept anonymous and unidentifiable to ensure the teachers' privacy and confidentiality.
The semi-structured interviews were held in the working environment of the interviewee and took between 45 and 90 min. The first 14 interviews were conducted by AM and RBW, in English, the last four interviews were done by MH in Dutch. AM is a physician and ethics teachers in Indonesia, RBW is a physician and teacher (in Indonesia) and cooperated with AM during the interviews and later transcribed part of the interviews. MH is an ethics teacher in the Netherlands and is, like AM, trained in doing qualitative research. AM and MH both met with alarming cases in their ethics classes and could therefore easily relate to the issue discussed.

In the first 14 interviews, the questions about the alarming cases were part of a larger list of open questions on the goals and organization of ethics education in the clerkship phase, as part of a comparative study between Indonesia and the Netherlands (Muhaimin et al. 2019, 2020). Somewhere in the interview, the following question was posed: *"Have you had any experience with hearing a case from a student that you thought was harmful for a patient or student, and that you thought you needed to do something about?"* This part of the interview took 15 to 20 min on average. We decided to focus on cases that students share with ethics teachers in an educational setting and not to mix these up with cases that students brought to an ethics department on their own initiative, for example to address medical misconduct.

After reading and analysing the transcripts by AM and MH, four more interviews, focusing on this topic alone, were conducted by MH (that took 45 to 60 min). In this way all Dutch academic hospitals were evenly represented in the study, and it also gave the team a chance to check if any new views or arguments on how to respond would pop up, which was not the case. We had reached data saturation.

Because of the limited number of interviews, we preferred to code and organize groups of codes manually (using excel sheets) instead of using a coding program. Analysis was done using a grounded theory approach and codes were regrouped several times (axially) to see what themes would emerge. MH and AM discussed analyses to reach a consensus in the interpretation. Creating a separation between teachers' practical reasons (to respond in this way or another) and more ideological motivations (to respond this way or another) appeared helpful to organize the data in a meaningful way. After analysis, the results were member checked with four interviewees.

Results

16 out of 18 teachers had indeed come across cases from interns they considered alarming. All of them stressed that this did not happen regularly though; alarming cases are considered exceptions.

Alarming cases

To give an impression of the kind of cases teachers mentioned, we present some examples in Table 1 below.

The focus of teachers in these cases was mainly on the learning environment of the student. Several teachers, for example, talked about medical errors made in the OR. Teachers were not so much alarmed by the error itself, but by the fact that it was silenced and that there had been no opportunity for the team and students to learn from mistakes made.

> *"Doctors in the OR panicked and were blaming each other, and interns were ordered to keep silent. An extreme bad example for students" (Interview 17)*

Cases that seemed to re-occur at a certain department evoked a stronger sense of alarm than singular incidents. Except for the case of vaginal touché, all alarming cases were not so much considered dilemmatic by teachers, but straight-out wrong.[2] Besides real

[2] Interns performing intimate examinations on patients in the OR, without the patient's consent. Some students and teachers were outraged by this 'common practice', others did not see real harm in it. On a national level the Royal Association of Medicine has clearly stated that this practice is not

cases, teachers also mentioned hypothetical cases or situations that would alarm them (see Table 2).

These results fit the outcomes of a research on medical students' narratives on professionalism dilemmas (Monrouxe and Rees 2012). It is well known that medical students can experience moral distress during their internships; they witness and participate in morally difficult situations, feel responsible and know what would be the right thing to do, but cannot always act as such because of institutional or hierarchical constraints (Monrouxe and Rees 2012; Wiggleton et al. 2010). The types of professionalism dilemmas that evoked the strongest negative emotions were consent dilemmas, patient safety and dignity breaches (by health care professionals) and abuse dilemmas (Monrouxe and Rees 2012). The cases that ethics teachers in our study considered alarming fall within these categories. This seems to imply that the teachers are alarmed by the same kind of cases as the ones that evoke moral distress in students.

Responding to an alarming case within class setting

The majority of ethics teachers wanted to guard a neutral position as long as possible, because they felt their primary task was to create a safe space for students in which they can express their ideas and feelings freely. Nevertheless, most teachers described a point where the non-judgmental position was given up.

> *"When it is a black area, I think we (as ethics teachers) should be clear about that" (Interview 14)*

From there on, some teachers used the alarming case as a means to reflect with students on their responsibilities and empower them by discussing ways to give feedback in a hierarchical system.

> *"They have to learn to address things as a clerk: if you don't do it then, you will not do it later. We learn students how to address things properly with the wrongdoer." (Interview 8)*

In some cases, teachers advised students to talk to their mentor or supervisor and discuss the case there, or to talk about it with peers. Occasionally, teachers approached a student after class and offered extra support. They would give students their email

allowed. On a global level, this practice is regularly topic of research (see for example Rees and Monrouxe 2011).

address for any additional guidance or questions or contact them afterwards and inform how things went. Teachers agreed that students should never be forced to take action.

> *"It is up to the intern to take action or not. Because you go into a procedure in which you are very vulnerable. The perpetrator, let's call it that, has the power, decides on your grade. And doing this anonymously is almost impossible. The perpetrator will find out who has reported it. So that is a very vulnerable position. And so I can understand why someone chooses to stay silent." (Interview 18)*

Literature on medical students' professionalism dilemmas indeed shows that medical students often avoid to speak up for fear of reprisal, of jeopardizing their future career, but also because they feel they lack necessary clinical knowledge and judgment, fear negative consequences on their grades and evaluations or feel they need to be a team player instead of 'rocking the boat' (Christakis and Feudtner 1993; Caldicott and Faber Langendoen 2005; Wiggleton et al. 2010).

Reasons for not intervening outside the scope of the classroom

Even though the teachers' responses described in the above section can have an effect outside the scope of the classroom, the initiative for taking action was still placed in the hands of the student. The teacher was there to support the student. But did teachers ever consider taking action themselves, outside the scope of the classroom? In other words, did teachers ever feel it was necessary or appropriate to actually intervene themselves? In this study, 12 out of 15 teachers were not eager to take action outside the scope of the classroom (that is, to intervene). This is a remarkable difference with the results of our earlier study on teachers' views in Indonesia, where the majority supported the idea of intervening (Muhaimin et al. 2021). In this section we present the main considerations Dutch teachers gave us for not intervening any further.

Ethics class should remain a safe place

As said before, the majority of our interviewees considered it an important part of their job to create a safe space for students to share and discuss their experiences. Of course, this is related to the fears that students have for speaking up, as described in the last paragraph.

> *"I can tell that they [the students] struggle a lot with this: that they see things and think 'this is not right' but choose to not tell because they still need to be evaluated. And I think it is great that they bring these issues to our ethics class, but then there needs to be a guarantee that their story will stay within the walls of the classroom and that the teacher cannot jeopardize students' position by*

going about and say: 'yeah well, we heard this and that about your department from an intern." (Interview 17)

We are not the moral police

There was a strong belief among our interviewees that ethicists and ethics teachers should be there to help doctors, not tell them what to do. The idea of taking action outside the classroom was often equated with morally judging.

"We don't focus on who did something wrong, we focus on what is the issue and how you should deal with it properly. We don't take action, no." (Interview 8)

"We are not the safeguard of the hospital. We are not the ethics police!" (Interview 11)

Some of the teachers also worked as an ethical moderator in the hospital. For them, this neutral position is closely linked to their training as moderator, often grounded in hermeneutics:

"My responsibility concerns the deliberation itself, not the situation discussed. This is also what I learned in my training as a moderator: to not participate, but to facilitate." (Interview 18)

The ethics teacher, hence, should not be a moralist, pointing fingers. On the contrary, the ethicist knows that it is often far from obvious what is the right thing to do. Two interviewees explained their aversion against judging, and intervening, as a reaction against the meddling of Protestant-Christian ethicists in debates on medical issues in the 70's and 80' in the Netherlands.

"I resist the idea that an ethicist is a sort of secular pastor who tells you what is the right thing to do" (Interview 18)

The ethics dance

The neutral position of the ethicists, facilitating and supporting doctors, was thus valued and emphasized by almost all our research participants. At the same time, this conviction was sometimes entangled with pragmatic considerations related to the position of ethicists in the hospital.

"Our teaching is embedded in this context of consultancy on one hand and ethics education on the other. We want to help the doctors, to do better or to think. This is a dangerous balance. Because you want to help them to improve, you don't want to say…., they should not feel that we are coming to tell them that what

they do is wrong, because the next time they don't come anymore." (Interview 11)

"If we do not guard our neutrality we undermine our own position, become broken-winged." (Interview 18)

"[As an ethics teacher] you have to dance this dance of co-insider and critical outsider and say: 'Yes, I am with you. We understand you being a doctor, it's hard work and you try to do the best within limitation.', but you also tell them: 'Okay, come out of this medical tunnel vision, and the idea that medicine is all about expertise and rationalism. Be realistic'…That's the dance we have to dance." (Interview 5)

Not our responsibility

The majority of the interviewees felt that it was other people's responsibility to address, report or intervene with alarming cases. In relation to the quality of care, and the wellbeing of patients, for example, responsibility was placed at the (future) caregivers.

> *"I don't want to know what doctor it was. I don't want that responsibility. It's you as future doctors who should consider taking action. That is not up to me" (Interview 5)*

Teachers told us that when students struggle with cases, emotionally or morally, there are other people available for supporting them, such as confidential counsellors or mentors. Teachers also encourage students to inform the coordinator of (master) education, as (s)he is considered ultimately responsible for the quality of education during the internships. Ethics teachers generally feel that they have a minor role in the training trajectory of students. Because of the large number of students and tightly packed medical curriculum, many ethics teachers see students only once or twice during their whole training. Ethics education has a volatile character, "we come in and go again."

> *"Is it up to me, to judge this situation, and ring the alarm bell, based on 1 moral deliberation-class? Or is it up to people who guide these students more closely, such as tutors, mentors or counsellors? Is this my responsibility? And then I eventually decided 'no'." (Interview 19)*

It is not do-able/we are not knowledgeable

The above point is also connected to another aspect of ethics teaching. To protect the confidentiality of patient information teachers are often not informed about the exact location [department] where the alarming case supposedly took place; cases are

anonymized. The case may even concern another care institutions or hospital, as interns often work outside the academic hospital.

> *"I never had the feeling I could do something about it, because the cases are depersonalized. I am not sure which hospital it is, and I don't even know most of the interns. It is not doable to act on that." (Interview 13)*

Another important, related factor mentioned by interviewees is that ethics teachers only hear half of the story. The student's versions of a case is often somewhat different than the version of the physician or care-givers on site. Ethics teachers, often not medically trained, feel they have to be very careful with handling this type of information.

> *"Sometimes there is a clinician present in ethics class, and they might know the case and add all kinds of relevant nuances, like 'no of course we talked with the family about this', or 'we tried really hard to figure out this alternative route', etc. Students can be quite blunt in how they describe a certain case, so that made me hesitant in responding too indignant." (Interview 17)*

Two more reasons were regularly mentioned by interviewees. First of all, the majority of the ethics teachers simply did not know where to go if they did want to address an alarming issue. In most ethics department there was no clear-cut route to deal with such issues or our interviewees did not know of them. Lastly, some teachers referred to their personality as the main reason for not taking action:

> *"I am not the activist type" (Interview 2).*

Considerations and circumstances in favor of intervening

Despite the overall reluctance, teachers also articulated ideological considerations in favour of intervening. Some teachers told us that the vulnerable position of medical students in the hierarchy of medical education should actually be an incentive to do take action, and not to remain silent (and guard a safe space at all times).

> *"I think the best way to intervene, normally, is to contact the senior doctor directly. But I think that is not fair to students, because students will not be in a position to say to a senior doctor 'well I heard that your behaviour is less than ideal'. So, then it should be on me." (Interview 12)*

Others told us why they feel an ethics teacher in particular has a moral responsibility to do something when she hears about an alarming case.

> *"Part of it is that we show students that we take them seriously and that ethical problems are serious problems. To teach them that ethics is not just a nice*

discussion without consequences… I expect students to behave in an ethical, or at least well-thought-manner, so I should do that myself as well…, like a sort of, in this aspect, a role model. (Interview 14)

There were also practical circumstances that could lead to or support a decision to intervene. When a case regularly popped up in stories of interns, pointing to structural problems at a certain department, the need to intervene increased for teachers. Sometimes teachers approached a head of department, or physician, directly because they happened to know him/her personally. These personal networks often played a role in one's possibilities for taking action. Teachers also remarked that it is helpful to have a background as a physician, or the status of a professor, when addressing an issue. In one department there seemed to be a certain routine for dealing with alarming cases as a team:

"I try to empower them (the students). When that doesn't work, or they are scared, we talk about it in the team, and sometimes, really sometimes, we decide to do something. And that can be anything, can be that we are going to talk to the specialist who supposedly did something wrong, or was hiding something, or we try to let it come out in the open without pointing fingers. That depends. I think most of the times, somehow, we find a way out. "(interview 11)

The existence of such a routine of intercollegiate consultation seemed helpful to create the support and possibilities, at least for considering taking action.

Lastly, we noticed that teachers' perspectives on the idea of intervening could change during te interview. By thinking more explicitly end lengthy about these alarming cases and how to respond to them, some teachers started to consider the option of taking action more seriously. Normally, after having felt shocked or overwhelmed by a case during class, they had been taken over by everyday worries soon afterwards and left the case as it was. During the interview they were given an opportunity to reflect more extensively on their experiences and became aware that many more ethics teachers come across such cases- making the cases change from an incident to a more structural (problematic) part of the job. So, during the interviews the urge to reflect with colleagues more regularly about this could increase.

"Your research question made me think: 'Should we not so something about this?'. Because everyone in this department does have the experience of reading a case and thinking "How is this even possible?". So, I discussed it [the research question] with my colleagues and we were thinking that maybe we should put it on the agenda of next departmental meeting. Because we do not do anything

about this now, but shouldn't we? We don't have a shared vision on this, like 'we should intervene', or 'we should not, because this is not our task'. We have all been dealing with this on or own." (Interview 17)

Actions taken outside class

To conclude the results section, we present an overview of actual actions taken outside of the classroom (Table 3). There was a certain chronology in the steps taken. First the case was discussed informally with a colleague. After that, in some departments teachers of the ethics department discussed the case together more formally, to decide whether action is appropriate and what that would look like. And only after that, 'real' interventions were done. Teachers continuously stressed that taking action should be done carefully, not only because of their own position, but even more so because of the doctors'. Things that had to be taken into account when actually approaching the physician or department concerned: inform yourself well beforehand about the case, if possible: address the issue directly with the physician/or head of department concerned (never behind someone's back), otherwise bring the issue forward without finger-pointing.

These results confirm the findings of Mannion and Davies in their research on the role of whistleblowing in health organizations (2015). They object to the idea, often found in policy prescriptions that the decision to 'blow the whistle' is a simple matter of individual choice between either speaking up or staying silent. Their research shows that "Before coming to any decision on whether to blow the whistle, employees usually find themselves trying to work out exactly what is happening, often through engaging in dialogue with colleagues and seeking a 'second opinion. "Also, they often look for more informal ways of addressing the issue before, or instead of, blowing the whistle formally (Mannion and Davies 2015).

Discussion

Literature on the ethical dilemmas of medical students has shown that the professional norms taught during the bachelor's phase, including being truthful, respecting patients and colleagues, putting the safety and care of patients first, can differ from the actual behaviour and situations they witness during the internships (Christakis and Feudtner 1993; Caldicott and Faber-Langendoen 2005; Wiggleton et al. 2010). This can also be

seen in the type of cases that our teachers considered alarming. Or as one of our respondents said:

> *"The biggest problem is that we teach an ethics that is not completely consonant with reality of medical practice. In year three I've taught them all and they lose a lot of their insights during the internships……So our biggest challenge [as ethics teachers] is retainment." (Interview 5)*

As a result, many medical students struggle with their moral integrity during the internships (Wiggleton et al. 2010; Berger 2013; Hamric 2012). Monrouxe and Rees (2012) state that students' predicament is partly due to a culture clash between the older and younger generation physicians. "By teaching them new norms, we send our students to the frontline of cultural change. It is our moral duty [as ethics teachers] to support them in this task." (Monrouxe and Rees 2012). In the setting of an ethics class teachers can try to help students discuss their experiences in a way that relieves tensions and discuss strategies to empower them (for beautiful examples see Berger 2013; Rogers et al. 2012; Gunderson et al. 2009; Gaufberg et al. 2010; Bell and Delbanco 2010).

However, as far as we know, no studies have been done on how ethics teachers perceive their role in this outside the scope of the classroom. Where do they feel their responsibility towards students' well-being, and patient care, begin and end? What kind of support can they offer to students who are at the frontline of cultural change? To bring the field of resident ethics further, we wanted more insight in how ethics teachers feel they should and can respond to signals they feel are worrying.

In our study we see that the Dutch ethics teachers we talked to were reluctant to take action outside class. This reluctance is partly rooted in the belief that an ethics teacher should stay neutral and facilitate reflection and open exchange of ideas, instead of telling students/doctors what to do. Related to this, an ethics class should be a safe space for students/doctors. This view on teaching seems to be historically grown as well as connected to the role and training of some Dutch ethics teachers as moderators in moral deliberations in hospitals.

Though this neutral and confidential position is highly valued by most teachers, it also seems a hard place to leave for those who would want to or feel they need to. Many interviewed teachers say it would be undoable, or at least very difficult to take action

outside the classroom. This has partly to do with the way in which ethics education is organized: the classes are confidential, cases anonymized and there are no long-terms connections between a teacher and a group of students/department. Moreover, many teachers just did not know where to go – there seemed to be no common or well-known route for dealing with alarming cases. This organizational structure hence supports this ideal of the ethicist as being a neutral and facilitating actor.

Some teachers said that the neutral position is a necessary precondition for the ethicist to be able to function in the hospital at all. The ethicist is allowed to support and offer reflection as long as she is not doing so in too much of a threatening way (ref. ethics dance).

This thought links up to some of the considerations we have seen in medical students. They also had a fear of speaking up about medical errors, because they did not want to jeopardize their position. They also wanted to be a team player instead of rocking the boat. And research, in for example the US, UK and Switzerland, has shown that these kinds of considerations can also be found among nurses, allied staff and even among physicians (Nembhard et al. 2015; Schwappach and Gehring 2014). As medical oncologist Srivastava writes: "When I ask colleagues, each recall sometimes harbouring misgivings about another doctor's treatment of a patient but feeling unable or reluctant to comment, even when a patient's life might be threatened -preferring to swallow their discomfort rather than challenge another physician's viewpoint." (Srivastava 2013).

One would expect this so-called silencing culture to come through in our interviews, but it was not addressed as such by the Dutch teachers. Perhaps ethics teachers do not consider themselves part of the organization in this way, also because their responsibility lies more in educating students than in patient care. At the same time, they do work in hospital settings where speaking up is not self-evident and can be considered threatening indeed. It could be an interesting topic to explore further.

When action was taken by ethics teachers, this was done with care and in all examples mentioned we can see serious attempts to guard a safe working environment for both students, teachers and doctors, as well as a safe environment for patients. We also saw

that practical circumstances could create more need and/or possibilities to intervene, such as the impact and content of the case, the background and position of the ethics teacher, their personal relational networks, and existing routines of communication about alarming cases within an ethics group. Context matters a lot in these delicate issues, and this might be an indication that ethics teachers indeed prefer to decide on intervening themselves, instead of having to stick to a standard reporting protocol. However, many respondents, also those who said they would never consider taking action, told us they would appreciate it if they could share and discuss alarming cases with colleagues more often.

> *"It would be nice to talk together about these things. I think it is sometimes underestimated, the things we all hear during our job." (Interview 19)*

Being neutral and, from there, facilitating open moral reflection, is and will remain a highly valued and anchored position among Dutch ethics teachers. But, based on these results, we do feel that there should also be some possibilities available for teachers to address an issue or intervene if they feel they need to. Because at this moment the ability to intervene is largely dependent on rather arbitrary circumstances, such as personal networks, strong individual beliefs or professional background. Looking at the needs expressed by our interviewees, a first step could be to discuss alarming cases with colleagues more regularly. By sharing such cases, teachers can stay better connected and knowledgeable of the learning environment of interns and respond, preferable as a group and/or anonymously, when deemed necessary. We agree with Ciasullo et al. (2017), that addressing unjust situations, that are harmful for patients or students, "should be understood as a collective, social, and cultural action rather than an individual initiative". Also, they can explicate together what they think their role as ethics teachers should (and should not) be in the hospital and what responsibilities come with this role. This can strengthen the incentive to actually do take action when needed (see also Henriksen and Dayton 2006).

To conclude: research shows that an important step in relieving the moral stress of interns is to confirm and acknowledge that the norms they learned in class can differ from the way things are done in medical practice. Perhaps the same counts for ethics teachers: If we want to be able to support students in the frontline of cultural change, we have to start to acknowledge the ways in which we, as ethics teachers, are (un)able to affirm or challenge existing norms in medical practice and together explore how we might want to proceed from there.

Limitations and further research

There are some limitations to our study. Firstly, the interviews were done by researchers who are ethics teachers themselves. Even though this means they could relate to the issue well, it could lead to too much of an insiders-situation during the interview as well as during data interpretation, lacking the fresh perspective of an outsider. We did have the advantage of having a mixed team with researchers from Indonesia as well as the Netherlands, which assured that interview data and interpretation were not self-evident to researchers and had to be discussed. Secondly, we only looked at cases that were brought in by students in ethics class. Students sometimes approach an ethics department outside the educational setting, to ask for help or support with a case that they feel is extremely worrying. In these situations, there is a direct appeal from the student to the ethics department (not so much the ethics teacher) to help and/or to intervene. We wanted to limit our study to settings in which there is no explicit appeal, to find out what ethics teachers' considerations are and to keep the research question as clear as possible. But by doing so, we had to block out cases that could have been informative on what routes are available for ethicists in the hospital to address i.e. misconduct.

Thirdly, the focus on neutrality in ethics teaching and moral deliberation might be typical for the Dutch setting; we have seen that in Indonesia this is not a central topic for teachers (Muhaimin et al. 2021). We do believe, however that the question of intervening or not can be a complicated matter for ethics teachers in many more countries. And that it is important for ethics teachers anywhere in the world to explore the (im)possibilities of addressing unjust situations from their specific positions in medical institutions.

This study does not reveal what other groups working and studying in the hospital think about the responsibilities and task of ethics teachers, such as medical students, physicians, mentors and managers, in relation to alarming cases. This would be an interesting topic to research further. We also think it would be valuable to take a next step and invite Dutch ethics teachers to sit together and exchange ideas, i.e. in a focus group, on what could or could not be appropriate routes for addressing alarming cases in a hospital setting as an ethics department.

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Availability of data and material (data transparency)

Because of confidentiality agreements with the interviewees, materials are only available on request.

Code availability

Not applicable.

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Declarations

Ethical approval

This study did not have any direct contact or interventions with patients, and therefore was not required to apply for ethical approval from the research ethics committees of the Amsterdam UMC.

Consent to participate

Interviewees were asked written permission to participate in the research after having been informed on the exact interview procedure.

Consent for publication

Interviewees were asked written permission for the researchers to publish results of this research. **Conflicts of interest/competing interests**

On behalf of the authors, the corresponding author states that there is no conflict of interest.

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CHAPTER 7

GENERAL DISCUSSION

In this final chapter, I will start with an overview of the main findings from the previous chapters, followed by discussing the implications of the findings for the development of ethics education in clinical clerkship training in the respective countries. I will then add a brief reflection on the research methodology and end this chapter with some reflections on my personal experience as a teacher in medical ethics as well as a medical doctor in Indonesia.

Main findings

The main findings will be presented in the order of the following research questions:

- What do medical students perceive as ethical problems in their daily training?
- What kind of ethical cases do medical students encounter during their clerkship?
- What do students expect and need from ethics education during the clerkship phase?
- What problems or challenges do teachers face in teaching ethics to medical students?
- What do teachers perceive as the learning goals of medical ethics?

Students' perceptions

Answering our first research question, we found that students in both settings perceived ethical problems as: (1) conflicting choices or something dilemmatic, (2) emotionally disturbing situations, (3) conflicts or problems concerning their duties and tasks as clerks, (4) unjust situations, and (5) poor quality of care. The differences in perception between students in the two countries were that Indonesian students often mentioned problems regarding justice and inequity in healthcare, and problems related to substandard or poor quality of care; while Dutch students more often mentioned about conflicting choices and ethical dilemmas. Some Dutch students also believed that the ethical problems worth discussing in class should be serious cases concerning life and death.

Students' actual cases

After having investigated what students *perceive* as ethical problems, we wanted to know what kind of ethical cases they encountered during their clinical training, which

lead to our second research question. We found that students in both settings encountered cases that were closer to their daily work and responsibility as medical students, as opposed to the *advanced* ethical dilemmas often discussed in existing literature in biomedical ethics. Ethical cases shared by students in both settings did not necessarily involve direct patient care, but instead were conflicts between students and supervisors or other healthcare workers. The difference was that the Indonesian cases were often related to lack of resources and poor quality of care, while Dutch cases were often about forced feeding and end of life decisions.

Dealing with emotions

In the interviews on students' perceptions, we found that students sometimes felt emotionally disturbed by the cases they encountered in their training site and were hesitant to share their emotions in class. Teachers also seemed uncertain on how to respond to students' emotions. We discussed why students had those negative (or positive) emotions and if teachers can or should question students' emotions. We categorized students' emotions based on their objects of reflection and came up with three categories: emotions concerning their own performance, emotions when witnessing unethical behaviour, and emotions related to barriers and limitations of their working environment. Our study suggests that addressing emotional responses in a culturally sensitive way is important to develop students' self-awareness. Teachers should be able to guide students to reflect on and be critical of their own thoughts and emotions and to understand their own moral values.

Teachers' perceptions

Finally, we explored teachers' perceptions from both countries on what they think are the most important learning goals for medical students. We found three similar goals between the two groups (with slightly different perceptions): (1) being professional, (2) dealing with ethical problems, and (3) being part of society. We also found four goals that were specific to the two countries: (1) *understanding one-self* and (2) *learning from others* in the Netherlands; and (3) *being faithful/pious* and (4) *obeying rules/standards* in Indonesia. Later in this chapter, we will discuss the gaps between what students perceive and experience during their clerkship and what teachers perceive and expect from students to be able to achieve from their ethics education. This will also answer our third question on what students need from their ethics education.

Dealing with alarming cases

This third topic is another follow up of our findings during the group discussions with medical students. We found that students sometimes bring in alarming ethical cases to discuss in class. We wanted to know how ethics teachers in Indonesia and the Netherlands would respond when they hear about a situation that they consider to be harmful and alarming, i.e., where patients' or students' safety is at stake. Since ethics class discussions are considered confidential, teachers were sometimes uncertain if they should maintain confidentiality, or if they should disclose the case to others outside of class to prevent further harm. We explored how teachers in both countries responded or would respond to such situation, including their reasons and arguments for doing so.

Alarming cases (real and hypothetical) that were reported from both settings included power abuse, fraud and deception, violation of patient's rights and autonomy, and sexual harassment. Most Indonesian teachers were convinced of the need to take action despite numerous perceived barriers. Those responses were mainly influenced by how Indonesian teachers perceive their role and responsibility as a *guru* and parents for students. Slightly different, Dutch teachers stated that they will address the issue in class but are overall reluctant to intervene or take action outside of class. This reluctance is partly rooted in the conviction that ethicists should stay neutral and facilitate reflection, instead of telling students or physicians what to do.

Implications

Students' perceptions: Why are they important?

In the context of medical ethics education, information on students' learning needs is important for teachers to develop learning strategies and offer individual feedback and support (Grant 2002). One of the reasons behind the idea to explore students' perception was that students (as well as teachers) in Indonesia have raised questions on what an ethical problem is, referring to various abstract definitions provided in the literature (Kuhse, Schuklenk, and Singer 2015; Beauchamp and Childress 2008). We believe that it is worthwhile to clarify this with both students and teachers for two reasons. First, there might be a tension between what students want to learn and what teachers think students should learn. Second, we can provide some insights for students using their own words and perception about what an ethical problem is, to prevent them from being hesitant to share any case they perceive as being ethically problematic. It might turn out to *simply* be a medical problem, but either way, students will learn how to distinguish ethical problems from non-ethical problems together with their peers and teachers.

Dilemmatic versus non-dilemmatic cases

From our study (see Chapter 2), we learned that leaving it open for students to decide what kind of ethical cases they want to share in class might be a good way to have a better insight into their clinical experience. Discussing non-dilemmatic cases, for instance reports of unethical behaviours, might be less interesting for some teachers, mainly because it is often obvious what should be done in such cases, or how one should behave in such circumstances. Teachers might also feel uncomfortable because it might give students the wrong impression that ethics teachers are some kind of *moral police,* and that ethics group discussions are merely intended for teachers to listen to students' complaints. However, discussing non-dilemmatic cases with students may be useful to practice ethical reflection and broaden students' (as well as teachers') perspectives about a certain ethical issue. Although a problem seems obvious at first, students as well as teachers may have different ways of seeing it, and therefore maybe worth to discuss together in class (Branch and George 2017; Marin 2020).

Dealing with moral distress and emotions

Students can experience moral distress from dealing with ethical issues they encounter in their learning environment (Rushton, Schoonover-Shoffner, and Kennedy 2017; Monrouxe et al. 2015; Berger 2014). We learned that ethics group discussions often become an "escape room" for students to *spill out* their ethical concerns and related emotions. It is a good sign that students can appreciate and consider the group discussions a free and safe place to share their thoughts and feelings, and a good opportunity for teachers to engage and respond to students in a more intimate way (Rees, Monrouxe, and McDonald 2013; Monrouxe and Rees 2012). However, there are challenges in opening space for students' emotions in class. As observed in our study, teachers often took much time to explore how students felt and therefore went beyond the allotted time. Teachers might also feel overwhelmed by the disturbing cases that students share. Hence, more time and preparedness from teachers will be needed. Nevertheless, we suggest that ethical discourses may help both students and teachers, to reflect on and deal with moral distress and cope with their emotions (Wiskin, Dowell, and Hale 2018; Terndrup 2013).

Teachers' perceptions: Why do they matter?

Although learning goals are normally well-defined in the curriculum and stated clearly in the learning modules, they are sometimes perceived differently by teachers. In the discussion below, I will further elaborate some of the perceived learning goals from teachers in our study that might be relevant and important for teachers in both countries to reflect on.

Ethics education: preparing students for clinical training and clinical practice

One of the goals of medical ethics education is to prepare medical students to deal with ethical issues and dilemmas later during their clinical practice (UNESCO 2008; Have and Gordijn 2014). Our concern/question is whether this goal is sufficient to also prepare for and support them in their role as clerks during their clinical training. From our study, we learned that students often shared, or *wanted to share*, cases that were closer to their role and responsibilities as clerks. It might not be a complicated clinical case related to advanced medical technologies, or the so called *sexy* ethical issues, as often discussed in contemporary textbooks on (bio)medical ethics (ref); or it might not

be a serious case involving life and death, or the so called *deadly* ethical cases. It might also not be an actual dilemma from the doctor's side, but rather from the student's side.

The cases that students share might *simply* be about how to communicate within the different levels of the hierarchical system; or about witnessing an unethical or unprofessional behaviour of other healthcare workers, whether to speak up and how to do so, etc. In this sense, ethics education should also prepare students for their role as clerks within a clinical training system, to be able to deal with ethical problems that might not have direct impact on patients. Students should be able to learn how to balance the two different roles: being a member of the medical team with limited responsibility towards patients and being a trainee with direct responsibility towards their supervisors. We suggest that ethics education should be able to prepare medical students early on for both their clinical training as well as future clinical practice.

Ethics and professionalism: learning and accepting different views

Dutch and Indonesian teachers in our study stated that one of the expected learning goals of medical ethics education is *being professional.* Despite using the same terminology, *being professional* was perceived rather differently in the respective countries. One thing that was not explored or discussed in the previous chapter is about how ethics and professionalism are related. Although there are numerous studies on ethics and professionalism in medicine, the relationship as well as the difference between the two have been rarely discussed. This could be relevant and important for teachers when designing the curricula and implementing learning strategies. While ethics discusses ethical norms and values, and how to make ethical decisions; professionalism discusses professional standards and how to adhere to those standards. Hence, ethics emphasizes the process and way of thinking and therefore is more open for discussion, while professionalism emphasizes adherence to certain rules or standards and therefore is less open (Ruitenberg 2016; Worthington 2015).

Ruitenberg (2016) discusses the difference and relationship between ethics and professionalism, and the implications for medical education. She illustrates their relationship using two partially overlapping spheres, namely *non-professional ethics* and *non-ethical professionalism.* This means that there are possible areas of ethics that may not pertain to professionalism, and vice versa. We can think of a case where a

physician may be considered *ethical but unprofessional*, or otherwise, *professional but unethical*. For example, a physician might decide to give a certain drug to a patient based on the patient's best interest but not report it in the medical record because it conflicts with the existing regulation or operational standards. In this sense, the physician's action may be considered ethical but unprofessional. In contrast, a teacher might be considered professional for implementing certain rules, for instance not allowing students who come late to class but considered unethical for being unfair in giving the sanction without considering any personal circumstances that may justify why the person is late, for instance having helped someone in a traffic accident.

Although I have my own perspective on the relationship between ethics and professionalism, which is rather similar to Ruitenberg's, in that ethics and professionalism are two partially overlapping spheres, I believe that it is logical and acceptable for teachers to have different views about this matter. This might be influenced by teachers' prior knowledge and contextual background (and purpose) for using the two terminologies in the first place. For instance, teachers and experts in the field of medical education more often discuss professionalism compared to ethics, to develop a more standardized learning method. Therefore, I do think it is important for teachers to understand the difference and relationship between ethics and professionalism, but I do not think it is worthwhile to further debate about which is more important and if ethics is part of professionalism, or otherwise.

Following rules and standards: a need for ethical reflection

The practice of medicine in Indonesia is said to be safeguarded by *ethics, discipline,* and *law*. In this sense, ethics, or *medical ethics*, is often referred to the Indonesian Medical Code of Ethics (KODEKI), developed by the Indonesian Medical Association (IDI); while discipline, or *professional discipline (Disiplin Profesional Dokter),* is referred to the Medical Council Regulations *(Peraturan Konsil Kedokteran)* established by the Indonesian Medical Council (KKI 2011). Hence, ethical discourses within the medical community as well as ethics teaching in medical schools in Indonesia often discuss issues surrounding breaches or violations of the code, discipline, or health law. This brings ethics closer to law, which is more focused on discussing rules, regulations, violations, and sanctions. This is very different from medical ethics teaching in the

Dutch setting, where the Dutch Code of Ethics *(KNMG-gedragsregels)* is very rarely mentioned during ethics case discussions in class.

Discussing ethical issues using rules, regulations, and standards may become problematic because merely following certain standards may not help in resolving (nor preventing) ethical problems and dilemmas because they may be conflicting with one another or conflicting with certain ethical principles. Perhaps ethics teachers, especially in the Indonesian setting, can organize some form of interdisciplinary discussion with teachers from law, philosophy, religion, etc. about the interplay between ethics, code of ethics, law, and religion. Inviting ethics teachers from other countries may also be beneficial to broaden perspectives. Teachers can also create more space for ethical reflection with students to be critical of their own profession, for instance by asking students to evaluate and reflect on their medical code of ethics, professional discipline, and existing health law, and discuss potential ethical issues that may arise from those existing regulations or standards.

Being part of society: on social justice, social responsibility, and solidarity

While the notion of justice, which emphasizes fairness and equity among individuals, is crucial for making ethical decisions in patient care, we believe that social justice is also an important notion to discuss with medical students. The concept of fairness within society and equity in healthcare, is perhaps a topic that needs more attention. There were numerous cases from the Indonesian setting where patients refused treatment due to financial constraints. Teachers can discuss with students, for instance, whether such cases could be considered as *refusal of treatment* and whether patients are considered *autonomous* if they have very limited freedom to choose what they want. Teachers can also ask if they think doctors, as well as students, have a moral or social responsibility to help patients, and to what extent they should carry out this responsibility. For instance, is it morally acceptable for students to bend the rules to help patients, as shown in our study, and how far should they *sacrifice* their own money and compromise their position to help patients?

We believe that such experiences are valuable for students to learn from and trigger student's moral resilience. However, having to deal with such issues daily may decrease students' moral sensitivity and inflict a sense of distrust to the healthcare system as well as educational system. Therefore, learning strategies such as debriefing are crucial for

students in such learning environments. In our study, Dutch students hardly had any experience in dealing with such cases because of their accessible healthcare system. This is clearly a positive aspect about the healthcare system. However, there were concerns from Dutch teachers on the lack of exposure for students on issues of solidarity, social responsibility, and social justice. Some teachers suggested that it would be good for Dutch students to have some clinical exposure abroad in developing countries and experience the *difficult* environment. Hence, initiating cross-cultural discussions on these kinds of issues with students might be beneficial to broaden perspectives and to reflect on the issues of social justice and solidarity.

Dealing with alarming cases: what should we do?

Since there are two separate chapters about this topic, from the Indonesian perspective and the Dutch, I would like to take the opportunity to make some comparison between the two countries and discuss how we can provide support for students regarding this issue. In general, we found that ethics teachers in Indonesia were assertive in wanting to intervene, while Dutch teachers were more reluctant. Indonesian teachers in our study view their role and responsibility as teachers exceeding beyond educational matters in class. They perceived their role as a *guru*, serving as a spiritual guide to promote noble character. Meanwhile, Dutch ethics teachers perceived their role as teachers as mainly to transfer ethical knowledge and skills, and to facilitate reflection. Some of the Dutch teachers in our study also had some training or double role as clinical ethics consultants who facilitate moral deliberations in hospitals. Therefore, they preferred to keep their neutral position (van der Dam et al. 2011; Shawahna 2018) and avoid giving too much guidance to let students find their own path and moral compass. Below is a summary of the discussion and comparison on teachers' responses and arguments from both settings.

There were differences between the two countries regarding the form of actions taken by teachers. In the Indonesian setting, teachers have reported alarming cases to the higher management (head of department, head of school, dean, etc.). In certain cases, however, teachers were more careful in disclosing or reporting alarming cases and looked for ways to improve and make changes to the system. This includes conducting proper research to justify their reports and action. In the Dutch setting, teachers preferred to discuss the case with their colleagues, organize some form of moral

deliberation or have an ethics consultation to consult their dilemma with a confidential counsellor. In both settings, however, teachers have also chosen for a personal approach if they had a close network or relationship with someone who was involved in the case. Teachers in both settings realized the barriers and limitations of what they can address and do in such situation. Many teachers said it would be very difficult to take action outside the classroom.

Table 1. Summary and comparison of teachers' responses and arguments

INDONESIA	THE NETHERLANDS
"Being assertive"	**"To intervene"**
Teachers were assertive in wanting to intervene. Their role is to promote noble character and are responsible for students throughout the training. The main goal of ethics education is to promote noble professionalism to build the nation.	Teachers were more likely to intervene depending on the impact and content of the case, their position, and relational networks. Teachers appreciate if they could share and discuss alarming cases with their colleagues.
"Being careful"	**"Not to intervene"**
Some teachers preferred to be careful and cautious, avoiding potential conflicts and minimizing further harm for all parties involved. Teachers are aware of their difficult position and maintaining harmony was highly valued.	Teachers' role is to facilitate open exchange of ideas and therefore should stay neutral. Ethical reflection is highly valued as the main goal in ethics education, and it is important to keep ethics class a safe place for students.

Our study shows that differences in teachers' background and position may (or may not) influence how teachers respond to alarming cases brought forward by students in class. Reports of alarming cases should be dealt with careful tact and diplomacy, and the privacy and confidentiality of students, patients, and other parties involved should be protected as much as possible. In cases where teachers feel the need to intervene or disclose the case and take action outside of class, we suggest that they should first discuss how to proceed with students themselves, to get some perspectives from the students' side, before discussing it outside of class. The complexity perhaps lies in *how to intervene* without causing further harm to all parties involved, including patients, students and healthcare workers. Finally, ethics group discussions should remain a free and safe place for students to share, discuss, and reflect on their experience in dealing with ethical problems and dilemmas.

Reflections on Research Methodology

Research setting

One of the major strengths of this study is that it is conducted in two different (and distant) countries, which gave us the opportunity to make some comparison. The study was initially designed as an explorative study and not a comparative study. However, it was difficult not to compare the results although it was not our intention in the first place. Moreover, the comparison helped us much in gaining a better understanding on the influence of contextual background and cultural traditions on students' and teachers' perceptions (Knipping 2003; Rittle-Johnson and Star 2011) as well as practices in medical ethics education in both countries. During the study, I had the privilege to travel multiple times between the two countries, while keeping my work and position as an ethics teacher in Indonesia. This gave me ample time to discuss and reflect on the findings of this study with colleagues (ethics teachers) from both countries. I also had the privilege of living in and experiencing both cultures throughout the study, which helped me much to understand better the beliefs, perceptions, contextual background, and cultural traditions of the participants in our study.

Nevertheless, reflecting on the process and findings from this study, I remember times when I had doubts about whether it was a good idea after all to compare the two countries, as people might say it is not *"apple to apple"*. Methodologically, it required sensitivity and flexibility on my side as a researcher to *switch* between cultures when approaching and communicating with participants in our study. For instance, communicating through social media was much preferred by Indonesian participants, while Dutch participants preferred e-mails; Dutch participants were more direct and assertive, while Indonesian participants were more indirect and *diplomatic* in sharing their feelings and thoughts. Exploring and comparing differences within Indonesia, with its diverse culture, might also be just as interesting. However, given that ethics teaching is somewhat new in Indonesia and only very few medical schools have included ethics teaching in their clerkship program, comparing Indonesia and the Netherlands seemed more relevant. Interestingly, it also revealed cultural similarities within the medical training system, possibly from the shared history between the two countries, if not the medical culture in general.

Participants and language

The limitations of our study were perhaps related to our selection of the research participants and language barrier. I would first like to reflect on the research participants. Medical students in our study only came from two medical schools, one in Indonesia and one in the Netherlands. Although we can argue that this is due to the explorative nature of our study, I realize that it might only represent a small group of students, especially for the Indonesian setting. This might not be an ideal method, particularly in a large country with a diverse culture like Indonesia. The challenge of conducting the observations in Indonesia was that there were very few (or hardly) any medical schools that had regular ethics classes or discussions in the clerkship at that time. This left us with very few and far away options within the country, which was technically, logistically difficult for me as a researcher. This was also more or less the case with Indonesian teachers in our study, who mostly came from Java (although we can also argue that more than one third of the medical schools in Indonesia are indeed located in Java). It was only during the pandemic in early 2020, one year after we completed data collection and analysis, that I realized the possibilities for conducting virtual in-depth interviews, and therefore would probably have given us more opportunity to include other teachers outside of Java.

The language barrier is perhaps one of the major limitations of this study, mainly due to my inability to speak Dutch and that English is also not my first language. Therefore, Dutch students and teachers had to speak English as their second (or third) language to participate in this study. I was very grateful that the Dutch students were always willing to speak in English when I was present in the group discussions, although they always had the option to speak Dutch; and I was always impressed to see how fluent they are in speaking English. I only recall having to drop two classes because a large part of the discussion was in Dutch, and it became too difficult for me to follow. Nevertheless, I realized how important it is to be able to express thoughts, feelings and emotions properly using our own language. Due to this limitation, we may have lost potential Dutch participants who were interested to participate in our study but were hesitant to speak in English. Perhaps hiring a research assistant for participants who preferred to speak Dutch for the in-depth interviews would have been an option. In the Indonesian setting, translation might have been another limitation. Although back-to-back translations from Bahasa Indonesia to English were carefully done, some words might

have slightly different meanings and therefore perceived differently by non-Indonesian readers.

Students' perceptions

One of my concerns about this study is regarding our first and second research questions. After our first paper on students' perception was published, I received a few comments and questions about the paper. As simple and logic as I thought the questions would be, I then realized that readers might have some trouble seeing the difference between the results of the two questions (see Chapter 2). The idea was that we wanted to know: (1) what students perceived as ethical issues or ethical problems, and (2) what kind of ethical cases they encountered. In answering the two questions, we started by asking the second. We asked students to share one case that they considered as an "ethical case". We then explored why they chose that particular case or why they considered the case as being ethically problematic, which then lead to the first question. We did not ask directly *what they perceived* as an ethical problem as we feared that the question might be too theoretical or that they would feel intimidated by the question. There is indeed some overlapping of the results, which might lead to confusion. However, there were two different purposes behind the two questions. The first was to provide some clue or hint for students on what an ethical issue or problem might be or feel like, in addition to the standard definition or theory. The second was to provide a list of clinical cases which often raise ethical issues, to add reference to the kind of ethical cases provided in contemporary textbooks on biomedical ethics.

Ethical dilemma

There was one particular case from the group discussion that was rather problematic for me, both as a researcher and teacher. The case was complicated and involved many parties, including medical students, physicians in training (residents), and senior doctors from different departments. The case was both alarming and emotionally disturbing because it involved abuse of power against the students, ending with the death of the patient and deception to the patient's family. The teachers felt that they should perhaps bring the case to someone outside of the department to prevent further harm to both students and patients. Therefore, we then discussed the case outside of class, where I was then asked for advice because I was considered the most senior among them. I was not sure what I should do with my position as a researcher and

decided not to get further involved. Eventually, the case was not disclosed to protect the students and because the teachers were not sure how they should proceed.

I often thought about the case afterwards and felt deeply concerned for future patients and the long-term consequences for students' learning process. I felt that my position as a researcher perhaps should not be a reason to limit myself in taking part to help the teachers. Perhaps I could or should have given more time to think about the dilemma before deciding. I thought that as a senior teacher, I could probably pave the way to discuss the case with colleagues from the clinical departments. It somehow did not feel right to keep the case for learning purpose or merely as research data. However, I also thought that the option, to step out of my role as a researcher and get involved, would probably not be a good example for the teachers. I thought that in such situation, it was more important to be clear about my position and stick to my role as a researcher and not a teacher. I think stepping out of my role as a researcher at that time might have consequences for my reliability as a researcher.

Reflections for teaching and clinical practice

My journey into medical ethics (or *bioethics*) education in Indonesia has been a *long and winding road* and more challenging than I had expected. First and foremost, I learned that ethics is perhaps the least interesting and least popular field for medical students as well as physicians, for many reasons. Second, ethics *(etika)* carry different meanings for different groups of people in Indonesia. For common people, ethics is often perceived as etiquette *(etiket)* or manner *(tata krama).* Although *etika* and *etiket* each have their own definition in the Indonesian Dictionary (ref KBBI), the two words indeed sound similar and they both discuss about norms and standards of behaviour. In the context of medical training and practice, ethics is also perceived as *professional behaviour*, *professional discipline*, or the medical *code of ethics.* Having all these different perceptions is sometimes confusing for myself, in the sense that I should be able to read where my interlocutor *(Indonesian: lawan bicara)* is coming from, *which ethics* they are referring to, and how I should then adjust myself and decide how I would want to proceed further with the conversation or discussion.

I would say that my perception about ethics was very much influenced by the western view, especially after pursuing a European master study in bioethics. I came to realize,

however, that I was not able to apply much of my knowledge back home. The western philosophical theories were often difficult to grasp, and the ethical issues were often related to highly advanced medical technologies, which we did/do not have in Indonesia. Moreover, ethical issues in public health and doctor-patient relationship were sometimes less relevant to discuss due to the different cultural context. Above all, ethics was perceived differently in Indonesia. Hence, we have our own ethical problems, which are very different from the western world. The idea of ethics as a discipline dealing with moral questions and decision making (Singer 2021) sometimes seemed irrelevant for the Indonesian context. Perhaps because the answers to those prevalent ethical problems seemed rather obvious: power abuse, fraud, corruption, bribery, are *simply* morally unacceptable. Therefore, as appealing and logical as it seems to introduce the *western notion* of ethics to students, I started to question myself if it was at all relevant and necessary. I also wondered how we could find a *middle ground* between the different perceptions, and how to introduce ethics in the clinical training phase properly.

The opportunity to conduct this study in the Netherlands gave me both, a chance to study and learn, and to take a step back and reflect on the work that I have been doing. The initial findings from the Indonesian setting were perhaps not that surprising from my previous ten years of experience in medical ethics teaching, but what came out of the discussions, especially the comparison between the two countries, were quite significant and meaningful for me. I have not only learned perspectives from students and teachers in both countries, but also learned to understand better why they were different and where those perspectives were coming from. Most importantly, I learned to accept the uniqueness from each country and to anticipate the challenges ahead about medical ethics teaching. Another valuable and practical thing that I learned from the Netherlands was the way teachers taught and discussed ethics in class with students. One of the most exciting experiences about this journey was having the privilege to learn directly in class, to observe and participate, how Dutch teachers engaged with students in an open learning environment that stimulates critical thinking.

Finally, had I learned how to make ethical decisions in medical school, I might have been more prepared and would not have felt *lost* during my clinical practice (see Chapter 1). Although my decisions might or might not have been different, I might

have had better reasons behind those decisions. Doing something simply because we are asked to do so, feels very different from doing something because we believe it is the right thing to do. And I think medical students will need ethics even more so today, not only due to advancements in medical technologies, but also due to the connected, digitalized, and globalized world, where people from different cultures and regions can easily connect and interact. Finally, I think my journey to the Netherlands has brought me "back home" to Indonesia, where I can now step on the ground more comfortably without feeling caught between east and west. I believe that teaching ethics, anywhere around the globe, requires sensitivity, modesty, and flexibility because context and culture matter much in the process as well as the outcome of what we want to deliver; and we should therefore understand which ground we are stepping on. As we say in Indonesia: ***"Di mana bumi dipijak, di situ langit dijunjung"*** *(where the earth is stepped on, there the sky is upheld)*. Perhaps this is something useful for me to keep in mind when teaching ethics.

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SUMMARY

Summary

Chapter 1 provides a general introduction to this thesis, which includes a background story behind the author's interest and reason to conduct this study. It starts with the author's personal experiences in dealing with ethical dilemmas during her early years as a medical doctor in Indonesia, and her concerns regarding ethics education, which led to various questions regarding medical ethics teaching during the clerkship phase. We therefore decided to explore the experiences and perceptions of both clerkship students and ethics teachers in two different countries, and try to answer the following questions: (1) what clerkship students perceive as ethical problems, (2) what kind of ethical cases they encounter, (3) what students need from their ethics education, (4) what challenges teachers face in teaching ethics, and (5) what teachers perceive as the learning goals of medical ethics. The first chapter also gives a brief historical background into medical ethics education in Indonesia and the Netherlands, including the historical ties between the two countries, and why we thought it was important to compare the two.

Chapter 2 tries to answer the first and second research question on what clerkship students perceive as ethical problems and what kind of ethical cases they encounter. We explored the experiences and perceptions of clerkship students in Indonesia and the Netherlands and compared results from the two countries. We observed a total of 18 ethics group discussions and interviewed 15 medical students at two medical schools. We found that students in both settings perceived ethical problems as problems related to their specific duties as clerks as well as problems that were emotionally disturbing. Ethical cases from both settings similarly involved conflicts between students and supervisors or other healthcare workers. The difference was that many Indonesian cases were about lack of resources and substandard care, while many Dutch cases were about forced feeding and end of life decisions. Our study suggests that there might be a gap between ethical problems that are discussed in class with teachers and problems that students encounter in practice. Teachers should be aware of the everyday situations in clinical training which may be perceived by students as ethically problematic.

Chapter 3 explores the feelings and emotions of Dutch and Indonesian medical students when dealing with ethical problems during their clinical training. In Chapter 2, we found that students sometimes felt emotionally disturbed by the cases they encountered and were hesitant to share their emotions in class. This chapter is one of the answers to our third research question on what clerkship students expect and need from their ethics education. We observed a total of 18 ethics group discussions and interviewed 15 medical students from two medical schools. We categorized students' emotions based on their objects of reflection and came up with three categories: emotions concerning their own performance, emotions when witnessing unethical behaviours, and emotions related to barriers and limitations of their working environment. Our study suggests that addressing emotional responses in a culturally sensitive way is important to develop students' self-awareness. Teachers should be able to guide students to reflect on and be critical of their own thoughts and emotions, and to understand their own moral values.

Chapter 4 provides insight into the perceptions of Dutch and Indonesian ethics teachers on what they think are the most important goals of ethics education for medical students and answers our last research question. It discusses the differences as well as similarities, between Dutch and Indonesian ethics teachers. We conducted in-depth interviews with 36 medical ethics teachers, 20 from Indonesia and 16 from the Netherlands and found three similar goals: (1) being professional, (2) dealing with ethical problems, and (3) being part of society. We also found four other goals that differed between the two countries: (4) *understanding one-self* and (5) *learning from others,* from the Netherlands; (6) *being faithful/pious* and (7) *obeying rules/standards,* from Indonesia. Our study shows that despite similar goals shared globally, there might be differences in how teachers in different cultural contexts perceive the goals with their local values and translate them into the curricula. We suggest that understanding those differences may be an important goal for teachers to broaden their knowledge and perspectives.

Chapter 5 explores how ethics teachers in Indonesia would respond to a student report of unethical or unprofessional behaviour during the clerkship phase that is alarming and potentially harmful for patients or students themselves. We conducted in-depth interviews with 17 teachers from 10 medical schools in Indonesia. The cases teachers

shared included power abuse, fraud and deception, violation of patient's rights and autonomy, and sexual harassment. We found that most teachers were convinced of the need to take action despite numerous barriers. Our study shows that formal education in ethics might not necessarily influence how teachers respond to alarming cases, and that their responses are mainly influenced by how they perceive their role and responsibility as teachers. We suggest that teachers should carefully consider the risks and consequences before taking action upon alarming cases to prevent further harm, and that support from higher authorities is crucial, especially in the Indonesian context. Most importantly, school leaders and administrators should develop effective organizational culture and support students and teachers for their ethical responsibility commitment. **Chapter 6** discusses the same topic as Chapter 5, but from the Dutch perspective. We explored what Dutch ethics teachers think a proper response would be when they are confronted with an alarming case brought in by medical students in class. Chapters 4 and 5 answers our fourth research question on what challenges teachers face during ethics teaching, and partly answers our third question on what students need, as this topic emerged during the group discussions with medical students. We interviewed 18 medical ethics teachers in the Netherlands. We found that Dutch teachers will address the alarming issue in class, but that they are overall reluctant to intervene and take action outside the scope of class. This reluctance is partly rooted in the conviction that ethicists should stay neutral and facilitate reflection, instead of telling students or physicians what to do. At the same time, this neutral position seems difficult to leave behind for those teachers who would want to or feel they need to. This has to do with various organizational and institutional constraints tied up with their position. The study invites medical ethics teachers to reflect on these constraints together and think about how to proceed from there.

Chapter 7 discusses the implications of the main findings for further practice and research. In this final chapter, we also used the opportunity to compare the results from Indonesia and the Netherlands, in particular Chapters 5 and 6. We also highlighted some of the unique findings from the respective countries, particularly regarding teachers' different perceptions on the learning goals of medical ethics. This includes discussing the difference between ethics and professionalism, on following rules and standards (especially for the Indonesian setting), and addressing issues of solidarity, social justice, and social responsibility. We suggest that medical ethics education should

be able to prepare students for their clinical training as well as clinical practice. This chapter also provides some reflection on the methodology and concludes with the author's personal reflection for further teaching and clinical practice.

Samenvatting

Hoofdstuk 1 geeft een algemene inleiding op dit proefschrift, inclusief een achtergrondverhaal over de interesse van de auteur en de reden om dit onderzoek uit te voeren. Het begint met de persoonlijke ervaringen van de auteur in het omgaan met ethische dilemma's tijdens haar vroege jaren als arts in Indonesië, en haar zorgen over ethiekonderwijs, wat leidde tot verschillende vragen over medisch-ethiekonderwijs tijdens de co-schappen. We hebben daarom besloten om de ervaringen en percepties van zowel coassistenten als ethiekdocenten in twee verschillende landen te onderzoeken, en proberen de volgende vragen te beantwoorden: (1) wat coassistenten ervaren als ethische problemen, (2) wat voor soort ethische gevallen ze tegenkomen , (3) wat studenten nodig hebben aan ethiekonderwijs, (4) met welke uitdagingen docenten worden geconfronteerd bij het onderwijzen van ethiek, en (5) wat docenten zien als de leerdoelen van medische ethiek. Het eerste hoofdstuk geeft ook een korte historische achtergrond van het medisch-ethische onderwijs in Indonesië en Nederland, inclusief de historische banden tussen de twee landen, en waarom we het belangrijk vonden om de twee te vergelijken.

Hoofdstuk 2 probeert de eerste en tweede onderzoeksvraag te beantwoorden over wat voor soort problemen coassistenten als ethisch ervaren en met wat voor ethische casussen ze te maken krijgen. We onderzochten de ervaringen en percepties van coassistenten in Indonesië en Nederland en vergeleken de resultaten uit de twee landen. We hebben in totaal 18 groepsdiscussies in het medisch ethiekonderwijs geobserveerd en 15 geneeskunde studenten geïnterviewd aan twee medische faculteiten, 7 in Nederland en 8 in Indonesië. We ontdekten dat studenten in beide settings de volgende problemen als ethisch ervoeren: problemen die verband hielden met hun specifieke taken als coassistent en problemen die verband hielden met emotioneel verontrustende zaken. Ethische casuïstiek uit beide instellingen betrof conflicten tussen studenten en supervisors of andere zorgverleners. Het verschil was dat veel Indonesische kwesties betrekking hadden op schaarste aan middelen en ondermaatse zorg, terwijl veel Nederlandse kwesties gingen over dwangvoeding en beslissingen rond het levenseinde. Ons onderzoek suggereert dat er een kloof kan bestaan tussen ethische problemen die in het onderwijs met docenten worden besproken en problemen die studenten in de praktijk tegenkomen. Docenten moeten zich bewust zijn van de alledaagse situaties

tijdens de coschappen die door studenten als ethisch problematisch kunnen worden ervaren.

Hoofdstuk 3 onderzoekt de gevoelens en emoties van Nederlandse en Indonesische geneeskundestudenten bij het omgaan met ethische problemen tijdens hun klinische opleiding. In hoofdstuk 2 vonden we dat studenten zich soms emotioneel belast voelden door de casuïsitek die ze tegenkwamen en aarzelden om hun emoties in de onderwijsbijeenkomsten te delen. Dit hoofdstuk is een van de antwoorden op onze derde onderzoeksvraag over wat co-studenten verwachten en nodig hebben van hun ethiekonderwijs. We hebben in totaal 18 groepsdiscussies over medische ethiek geobserveerd en 15 geneeskunde studenten van twee medische faculteiten geïnterviewd. We categoriseerden de emoties van studenten en kwamen tot drie categorieën: emoties met betrekking tot hun eigen prestaties, emoties bij het zien van onethisch gedrag bij anderen en emoties gerelateerd aan barrières en beperkingen van hun werkomgeving. Onze studie suggereert dat het belangrijk is om emotionele reacties op een cultureel gevoelige manier aan te pakken om het zelfbewustzijn van studenten te ontwikkelen. Docenten moeten studenten kunnen begeleiden bij het nadenken over en kritisch zijn op hun eigen gedachten en emoties, en bij het leren begrijpen van hun eigen morele waarden.

Hoofdstuk 4 geeft inzicht in de ideeën van Nederlandse en Indonesische docenten medische ethiek over wat de belangrijkste doelen zijn van het ethiekonderwijs aan geneeskundestudenten en geeft antwoord op onze laatste onderzoeksvraag. Het bespreekt zowel de verschillen als overeenkomsten tussen docenten medische ethiek in Nederland en Indonesië. We hebben diepte-interviews afgenomen met 36 docenten medische ethiek, 20 uit Indonesië en 16 uit Nederland en vonden drie vergelijkbare onderwijsdoelen: (1) professioneel zijn, (2) omgaan met ethische problemen en (3) deel uitmaken van de samenleving. We vonden ook vier doelen die specifiek waren voor eén van de twee landen, namelijk bij docenten in Nederland: (4) zichzelf begrijpen en (5) leren van anderen, en bij docenten in Indonesië:; (6) trouw/vroom zijn en (7) regels/normen gehoorzamen. Ons onderzoek laat zien dat ondanks vergelijkbare doelen, die wereldwijd worden gedeeld, er verschillen kunnen zijn in de manier waarop docenten in verschillende culturele contexten de doelen vanuit hun lokale waarden waarnemen en deze vertalen in de leerplannen. We suggereren dat het begrijpen van

die verschillen een belangrijk doel kan zijn voor docenten om hun kennis en perspectieven te verbreden.

Hoofdstuk 5 onderzoekt hoe docenten ethiek in Indonesië zouden reageren op een melding van onethisch of onprofessioneel gedrag door studenten tijdens het coschap, dat alarmerend en mogelijk schadelijk is voor patiënten of studenten zelf. We hebben diepte-interviews gehouden met 17 docenten van 10 medische faculteiten in Indonesië. De gevallen die docenten deelden, waren onder meer machtsmisbruik, fraude en bedrog, schending van de rechten en autonomie van de patiënt en seksuele intimidatie. We ontdekten dat de meeste docenten overtuigd waren van de noodzaak om ondanks tal van barrières actie te ondernemen. Ons onderzoek toont aan dat het hebben gehad van formeel onderwijs in ethiek niet noodzakelijkerwijs van invloed hoeft te zijn op hoe docenten reageren op alarmerende gevallen, en dat hun reacties voornamelijk worden beïnvloed door hoe zij hun rol en verantwoordelijkheid als docenten waarnemen. We stellen voor dat docenten de risico's en gevolgen zorgvuldig overwegen voordat ze actie ondernemen bij alarmerende gevallen om verdere schade te voorkomen, en dat steun van leidinggevenden van cruciaal belang kan zijn, vooral in de Indonesische context. Het belangrijkste is dat onderwijsbestuurders een effectieve organisatiecultuur moeten ontwikkelen en studenten en docenten moeten ondersteunen bij hun inzet voor ethische verantwoordelijkheid.

Hoofdstuk 6 behandelt hetzelfde onderwerp als hoofdstuk 5, maar dan vanuit Nederlands perspectief. We onderzochten wat Nederlandse ethiekdocenten een gepaste reactie vinden als ze in de onderwijsbijeenkomsten worden geconfronteerd met een alarmerende casus die door studenten geneeskunde wordt aangedragen. We hebben 18 docenten in Nederland geïnterviewd en vonden dat zij de alarmerende kwestie in de onderwijsbijeenkomsten zullen bespreken in de groep, maar dat ze over het algemeen terughoudend zijn om in te grijpen en actie te ondernemen buiten de onderwijsbijeenkomsten. Deze terughoudendheid is deels geworteld in de overtuiging dat ethici neutraal moeten blijven en reflectie moeten faciliteren, in plaats van studenten of artsen te vertellen wat ze moeten doen. Tegelijkertijd lijkt deze neutrale positie moeilijk te verlaten voor die docenten die dat zouden willen. Dit heeft te maken met verschillende organisatorische en institutionele beperkingen die aan hun functie verbonden zijn. Het onderzoek nodigt docenten medische ethiek uit om samen over

deze beperkingen na te denken en na te denken over hoe het verder moet. Hoofdstukken 5 en 6 beantwoorden onze vierde onderzoeksvraag over de uitdagingen waarmee docenten worden geconfronteerd tijdens het lesgeven in ethiek, en beantwoorden gedeeltelijk onze derde vraag over wat studenten nodig hebben, aangezien dit onderwerp naar voren kwam tijdens de groepsdiscussies met medische studenten.

Hoofdstuk 7 bespreekt de implicaties van de belangrijkste bevindingen voor de onderwijspraktijk en onderzoek. In dit laatste hoofdstuk hebben we van de gelegenheid gebruik gemaakt om de resultaten uit Indonesië en Nederland onderling te vergelijken, met name de hoofdstukken 5 en 6. We belichten ook enkele van de unieke bevindingen uit de respectieve landen, met name met betrekking tot de verschillende percepties van docenten over de leerdoelen van medische ethiek. Dit omvat het bespreken van het verschil tussen ethiek en professionaliteit, het volgen van regels en normen in de Indonesische setting, en het aanpakken van kwesties van solidariteit, sociale rechtvaardigheid en sociale verantwoordelijkheid. We stellen voor dat onderwijs in de medische ethiek studenten moet kunnen voorbereiden op hun klinische opleiding en klinische praktijk. Dit hoofdstuk geeft ook enige reflectie op de methodologie en sluit af met de persoonlijke reflectie van de auteur voor verder onderwijs en klinische praktijk.

Ringkasan

Chapter 1 adalah pengantar tesis, yang mencakup latar belakang cerita dibalik minat dan alasan penulis melakukan penelitian ini. Berawal dari pengalaman pribadi penulis dalam menghadapi dilema etik di tahun-tahun awal berpraktik sebagai dokter di Indonesia, dan kepedulian terhadap pendidikan etika, berbagai pertanyaan timbul tentang pembelajaran etika kedokteran selama fase kepaniteraan klinik. Kami memutuskan untuk mengeksplorasi pengalaman serta persepsi mahasiswa kepaniteraan (koasisten) dan dosen etika kedokteran di Indonesia dan Belanda, dan mencoba menjawab pertanyaan-pertanyaan berikut: (1) apa yang dipersepsikan mahasiswa sebagai masalah etika, (2) jenis kasus etik apakah yang mereka hadapi, (3) apa yang dibutuhkan mahasiswa dari pendidikan etika, (4) tantangan apa yang dihadapi dosen dalam mengajar etika, dan (5) apa persepsi para dosen etika sebagai tujuan pembelajaran etika kedokteran. Chapter ini juga memberikan latar belakang sejarah singkat tentang pendidikan etika kedokteran di Indonesia dan Belanda, termasuk sejarah hubungan kedua negara, dan mengapa penting untuk membandingkan keduanya.

Chapter 2 mencoba menjawab pertanyaan penelitian pertama dan kedua tentang apa yang dipersepsikan mahasiswa (koasisten) sebagai masalah etik dan jenis kasus yang dihadapi. Kami mengeksplorasi pengalaman dan persepsi mahasiswa di Indonesia dan Belanda dan membandingkan hasilnya. Kami melakukan observasi pada 18 kelompok diskusi dan mewawancarai 15 mahasiswa di dua sekolah kedokteran. Hasilnya menunjukkan bahwa mahasiswa di kedua negara menganggap masalah etik sebagai permasalahan yang terkait tugas mereka sebagai koasisten dan masalah-masalah yang mengganggu secara emosional. Jenis kasus etik dari kedua negara termasuk diantaranya kasus-kasus yang melibatkan konflik antara mahasiswa dan supervisor atau petugas kesehatan lainnya. Perbedaannya adalah bahwa kasus di Indonesia banyak terkait dengan kurangnya sumber daya dan kualitas perawatan pasien, sementara kasus di Belanda terkait dengan pengambilan keputusan pada end of life. Studi ini menunjukkan adanya kemungkinan kesenjangan antara masalah etik yang dibahas di kelas dengan masalah yang dihadapi siswa dalam praktik.

Chapter 3 mengeksplorasi perasaan dan emosi mahasiswa kedokteran Belanda dan Indonesia ketika menghadapi masalah etik selama kegiatan kepaniteraan klinik. Dalam

Chapter 2, kami menemukan bahwa mahasiswa terkadang merasa terganggu secara emosional dengan kasus yang dihadapi dan ragu untuk mengekspresikan emosi mereka di kelas. Chapter ini adalah salah satu jawaban atas pertanyaan penelitian ketiga tentang apa yang diharapkan dan dibutuhkan oleh mahasiswa
kepaniteraan dari pendidikan etika. Hasil observasi pada 18 kelompok diskusi dan wawancara 15 mahasiswa di dua sekolah kedokteran menemukan tiga kategori emosi siswa berdasarkan objek refleksinya: emosi terkait kinerja mereka sendiri, emosi ketika menyaksikan perilaku yang tidak etis, dan emosi terkait keterbatasan lingkungan kerja mereka. Studi ini menunjukkan pentingnya menghadapi respon emosional dengan kepekaan budaya untuk mengembangkan kesadaran diri siswa. Para dosen etika harus mampu membimbing siswa untuk berefleksi dan kritis terhadap pikiran dan emosi dirinya agar dapat memahami nilai-nilai moral mereka sendiri.
Chapter 4 memberikan wawasan tentang persepsi dosen etika di Belanda dan Indonesia tentang apa yang dipersepsikan mereka sebagai tujuan terpenting dari pendidikan etika bagi mahasiswa kedokteran dan menjawab pertanyaan penelitian terakhir. Kami melakukan wawancara mendalam dengan 36 dosen etika kedokteran, terdiri dari 20 dosen Indonesia dan 16 dosen Belanda. Terdapat tiga tujuan yang sama: (1) menjadi profesional, (2) mampu menghadapi masalah etik, dan (3) menjadi bagian dari masyarakat. Selain itu, kami menemukan empat tujuan lain yang berbeda diantara kedua negara. Dosen etika di Belanda menyatakan penting untuk tujuan (4) memahami diri sendiri dan (5) belajar dari orang lain; sedangkan dosen di Indonesia mengekspresikan pentingnya (6) beriman dan bertakwa, serta (7) menaati peraturan atau regulasi. Studi ini menunjukkan bahwa meskipun terdapat banyak kesamaan secara global, namun ada perbedaan dalam cara dosen memahami tujuan pembelajaran dengan nilai-nilai budayanya dan menerjemahkannya ke dalam kurikulum. Memahami perbedaan persepsi tentang tujuan pembelajaran tersebut menjadi penting bagi para dosen untuk memperluas pengetahuan dan perspektif mereka.

Chapter 5 mengeksplorasi bagaimana dosen etika di Indonesia menanggapi laporan mahasiswa tentang kasus etik yang mengkhawatirkan dan berpotensi membahayakan pasien atau siswa sendiri. Kami melakukan wawancara mendalam dengan 17 dosen dari 10 fakultas kedokteran di Indonesia. Kasus-kasus tersebut meliputi penyalahgunaan wewenang, penipuan, pelanggaran hak dan otonomi pasien, serta pelecehan seksual. Kami menemukan bahwa sebagian besar dosen percaya akan perlunya mengambil

tindakan terlepas dari banyak kendala. Studi ini menunjukkan bahwa pendidikan formal di bidang etika tidak selalu mempengaruhi bagaimana dosen etika menanggapi kasus-kasus tersebut, dan bahwa respon mereka terutama dipengaruhi oleh bagaimana mereka memandang peran dan tanggung jawab mereka sebagai guru. Kami menyarankan agar para dosen mempertimbangkan dengan hati-hati risiko dan konsekuensi sebelum mengambil tindakan atas kasus-kasus yang mengkhawatirkan tersebut, untuk mencegah kerugian lebih lanjut. Dukungan dari otoritas yang lebih tinggi menjadi penting, terutama dalam konteks di Indonesia. Pimpinan institusi perlu mengembangkan budaya organisasi yang efektif dan mendukung mahasiswa dan dosen untuk berkomitmen pada tanggung jawab etik mereka.

Chapter 6 membahas topik yang sama dengan Chapter 5 tetapi dari sudut pandang dosen etika di Belanda. Kami mengeksplorasi apa respons yang tepat menurut dosen etika di Belanda ketika dihadapkan pada kasus yang mengkhawatirkan. Chapter 5 dan 6 menjawab pertanyaan penelitian keempat terkait tantangan yang dihadapi oleh dosen selama mengajar etika, sekaligus menjawab pertanyaan ketiga tentang apa yang dibutuhkan mahasiswa. Kami mewawancarai 18 dosen etika dari 8 fakultas kedokteran di Belanda dan menemukan bahwa dosen etika di Belanda secara umum enggan untuk melakukan intervensi dan mengambil tindakan di luar kelas. Keengganan ini sebagian berakar pada keyakinan bahwa dosen etika seharusnya bersikap netral dan memfasilitasi refleksi, bukan memberitahu siswa apa yang harus dilakukan. Di saat yang bersamaan, posisi netral ini dianggap sulit bagi sebagian dosen yang merasa perlu untuk melakukan sesuatu. Hal ini berkaitan dengan berbagai kendala dalam institusi serta posisi mereka. Studi ini mengajak para dosen etika kedokteran untuk bersama merenungkan kendala-kendala tersebut beserta implikasi selanjutnya.

Chapter 7 membahas implikasi dari temuan-temuan utama untuk praktik pembelajaran etika dan penelitian lebih lanjut. Pada chapter terakhir ini, kami membandingkan hasil Indonesia dan Belanda, khususnya dari Chapter 5 dan 6. Kami juga menyoroti beberapa temuan unik dari setiap negara, terutama perbedaan persepsi dosen tentang tujuan pembelajaran, termasuk diantaranya perbedaan antara etika dan profesionalisme, mengikuti standar serta aturan (khususnya pada konteks Indonesia), dan masalah solidaritas, keadilan sosial, dan tanggung jawab sosial. Kami menyarankan agar pendidikan etika kedokteran harus dapat mempersiapkan siswa untuk menjalani

pelatihan/kepaniteraan klinik dan sekaligus melakukan praktek klinik di kemudian hari. Chapter ini juga memberikan beberapa refleksi terkait metodologi dan diakhiri dengan refleksi pribadi penulis untuk praktik kedokteran serta praktik pembelajaran dan pengajaran etika kedokteran selanjutnya.

PHD PORTFOLIO

PhD Portfolio

Name PhD student : **Amalia Muhaimin**
PhD period : April 2016 – September 2022
Names of PhD supervisor(s) : **Prof. dr. Derk L. Willems, Ph.D**
Prof. dr. Adi Utarini, M.Sc., MPH, Ph.D
Name of PhD co-supervisor : **Dr. Maartje Hoogsteyns**

1. PhD training

Activities	Year	ECTS
General courses		
Endnote (AMC)	2016	0.1
Embase/Medline via Ovid (AMC)	2016	0.1
Basic Course Qualitative Health Research (AMC)	2016	1.9
Qualitative Research Methods (UvA – Coursera)	2017	1.6
Quantitative Research Methods (UvA – Coursera)	2017	1.3
Scientific Writing in English for Publication (AMC)	2017	1.5
Oral Presentation in English (AMC)	2017	0.8
The AMC World of Science (AMC)	2017	0.7
Practical Biostatistics (AMC)	2017	1.1
Teaching Skills for PhD Candidates (UvA)	2018	0.9
Specific courses		
Zurich-Harvard Intensive Bioethics Course (ZHIBC)	2018	1.0
Seminars, workshops and master classes		
Philosophy of Care meetings (monthly). Amsterdam UMC location AMC.	2016-2021	1.0
Intensive Workshop on Clinical Ethics. FK UGM, Yogyakarta, Indonesia	2018	0.5
UNODC Expert Workshop for University Lecturers “Enhancing Capacity to Teach Anti-Corruption, Integrity and Ethics”. Bandung, Indonesia.	2019	0.5
Presentations		
“Teaching Bioethics in Indonesia”. Intensive Bioethics Training Course on Teaching, Manuscript and Thesis Writing, Perdana University Malaysia.	2016	0.5

"Engaging with emotions and culture in ethics teaching – lessons from Indonesia". The 1st Asia Pacific Bioethics Education Network (APBEN) Conference.	2020	0.5
"Ethics education should make room for emotions". Weekly *Raboan* Meeting, Center for Bioethics and Medical Humanities, Faculty of Medicine, Universitas Gadjah Mada.	2021	0.5
"Ethics or Professionalism? Reflections on medical education & clinical practice in Indonesia". The 1st Jenderal Soedirman Intemational Medical Conference (JIMC).	2020	0.5

(Inter)national conferences		
The 17th Asian Bioethics Conference. Towards a peaceful world: Empathy and Dialogue on Asian Transcultural Bioethics. Yogyakarta, Indonesia. (participant)	2016	0.5
The 5th SEARAME International Conference: Improving the Quality of Health Professions Education. Yogyakarta, Indonesia. Presentation: *Ethical Dilemma or Ethical Misconduct? A reflection on medical ethics teaching in Indonesia*	2017	0.5
UNODC International High-Level Conference. "Educating for the rule of law: Inspire. Change. Together." Vienna, Austria. (participant)	2019	0.5
The 21st Asian Bioethics Conference. Bioethics in the Covid-19 Era. Bangkok, Thailand (virtual). Presentation: *To Intervene or Not? Dutch and Indonesian ethics teachers' on how to respond when hearing alarming cases from medical students in class*	2021	0.5
International Conference on Medical Education (ICME) 2021. Excellence in Health Profession Education: Through Globalization an Collaboration. Yogyakarta, Indonesia (virtual). (participant)	2021	0.5

2. Teaching (at the Faculty of Medicine, Universitas Jenderal Soedirman, Indonesia)

Activities	Year	ECTS
Lecturing		
Course (Block 3.1): Ethics and Medical Humanities	2016-2021	1
Course (Block 5.1, 5.3, 6.1, 6.3, 7.2, 7.4): Biomedical Ethics	2016-2021	1
Course (Block 5.2): Research Methodology & Research Ethics	2016-2021	1
Tutoring, Mentoring		
Ethical Case Discussion. Dept. of Forensic & Medico-Legal. (Clerkship Program)	2019-2022	1

Effective Communication. Clinical Skills Laboratory. (Bachelor in medicine)	2020-2022	0.5
Delivering Bad News. Clinical Skills Laboratory. (Bachelor in medicine)	2020-2021	0.5
Clinical Reasoning. Clinical Skills Laboratory. (Bachelor in medicine)	2020-2022	0.5
Ethical Case Report. Dept. of Surgery. (Clerkship Program)	2021-2022	1
Clinical Case Discussions (PBL). (Bachelor in medicine)	2021-2022	
Supervising		
Research/thesis for bachelor students in medicine (2)	2021-2022	1

3. Publications

Peer reviewed	Year
Muhaimin, A., Willems, D. L., Utarini A, Hoogsteyns, M. (2019). What Do Students Perceive as Ethical Problems? A Comparative Study of Dutch and Indonesian Medical Students in Clinical Training. *Asian Bioethics Review*, *11*(4), 391-408.	2019
Muhaimin, A., Hoogsteyns, M., Willems, D. L., & Utarini, A. (2020). Ethics education should make room for emotions: a qualitative study of medical ethics teaching in Indonesia and the Netherlands. *International Journal of Ethics Education, 5, 7-21.*	2020
Muhaimin, A., Hoogsteyns, M., Wicaksono, R.B. *et al.* (2021). "I would do something if I could!": Experiences and reflections from ethics teachers on how to respond when hearing alarming cases from medical students. *BMC Medical Education, 21*, 233.	2021
Hoogsteyns, M. & Muhaimin, A. (2021). Staying neutral or intervening? Ethics teachers' ideas on how to respond to alarming cases brought forward by medical students in class: A qualitative study in the Netherlands. *International Journal of Ethics Education, 6*(2), 273-288.	2021
Rujito, L., Nandhika, T., Lestari, D. W. D., Ferine, M., & Muhaimin, A. (2020). Genetic Literacy Levels and Genetic Screening Attitudes on Medical Students in Indonesia: A National Survey. *Malaysian Journal of Public Health Medicine*, *20*(3), 1-8.	2020
Wicaksono, R. B., Ferine, M., Lestari, D. W. D., Hidayah, A. N., & Muhaimin, A. (2021). Experience of Indonesian medical students of ethical issues during their clinical clerkship in a rural setting. *Journal of Medical Ethics and History of Medicine*, *14,* 6.	2021
Muhaimin, A., Hoogsteyns, M., Dwi Lestari, D.W., Ferine, M., Utarini, A., Willems, D.L. (2022). Dutch and Indonesian teachers on teaching medical ethics: what are the learning goals? *Medical Education Online*, 27:1.	2022

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ABOUT THE AUTHOR

About the author

Amalia Muhaimin was born in Bumiayu, a small town in Central Java, Indonesia. After obtaining her medical degree in 1999 at the Faculty of Medicine Universitas Diponegoro in Semarang, she started her work as a general practitioner in Semarang and Jakarta in small outpatient clinics. In July 2000, she settled back in Yogyakarta where she had lived before during her junior and senior high school, and continued her clinical practice in a children and maternity hospital in the region of Kotagede until the end of 2006.

Intrigued by ethical dilemmas encountered during her practice, Amalia decided to work part time at the Center for Bioethics and Medical Humanities (CBMH) at the Faculty of Medicine Universitas Gadjah Mada in Yogyakarta, from 2003-2006, where she was involved in a research project on End of Life Care in collaboration with Harvard Medical School. During this period, she explored ethical issues surrounding residency/specialty training and became interested in ethics education during clinical training.

Amalia started her teaching career in 2007 at the Faculty of Medicine Universitas Jenderal Soedirman in Purwokerto, where she became a full-time lecturer at the Department of Bioethics and Humanities until present. Pursuing her interest in bioethics, in 2011 she joined the Erasmus Mundus Master of Bioethics program, hosted by Katholieke Universiteit Leuven in Belgium, Radboud UMC in the Netherlands, and the University of Padova in Italy, where she obtained an advanced master's degree (M.Sc.) in Bioethics.

In 2016, Amalia was awarded the BPP-LN DIKTI scholarship by Indonesia's Ministry of Research, Technology, and Higher Education to conduct her PhD study at the Academic Medical Center (now Amsterdam University Medical Center), University of Amsterdam. Her study focused on ethics teaching during the clerkship phase in Indonesia and the Netherlands, conducted in both countries. Currently, her main area of interest includes ethics education as well as ethics consultation for medical students.