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Trainee Conceptualisation of Feedback in a South East Asian Setting: An Interpretive Description Study

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Abstract

Background:

Feedback is acknowledged as a key component of learning and development of healthcare professionals. A scoping literature review indicated that Culture influenced the seeking and acceptance of feedback by Asian health professional trainees. This study was conducted to further explore the understanding and utilisation of feedback in clinical settings by trainees in an Australian University based in Malaysia.

Methods:

Interpretive Description was used as the methodological approach. This study involved penultimate year medical trainees from a clinical school based in Johor Bahru, Malaysia. Trainees were recruited by notices in the school and in tutorials, followed by a Zoom meeting to explain in detail before being invited to participate (35 trainees participated in the study). Participants attended two, semi-structured group interviews; 10 entry-group interviews were held mid-2022, 8 exit-group interviews held 3 months later. Participants were invited to submit diaries of feedback experiences between group interviews – 62 diaries submitted by 24 trainees (1 – 5 diaries submitted by each of these trainees). An initial coding framework was developed with input from the research team and iteratively refined through a series of team discussions to identify and consolidate themes.

Results:

From the trainee perspectives we identified two themes. The first theme is 'Trainee conceptualisation of feedback' the dominant conception was 'feedback as telling', but comments without advice to improve were not considered feedback). The second theme is 'Trainee experience of feedback', encapsulating two aspects: Power distance, hierarchy and humiliation (seen both in the use of embarrassment in teaching and reluctance of trainees to question or provide feedback to supervisors) and collectivism, peer feedback and uncertainty in the context of group and peer feedback. Group feedback was used at bedside teaching and recognised as appropriate yet often considered vague. Peer feedback was encouraged at bedside teaching, but perceptions of peer feedback were varied or ambivalent. Uncertainty about feedback provided caused distress.

Conclusions:

Feedback was generally understood as *telling* and error correction. Trainees experienced and observed feedback being given in a harsh manner, but most accepted that approach as valid, as long as they were also given advice about how to improve or correct the errors. Multiple cultures appeared to be at play – the education system culture and workplace culture appeared to interact with ethnic Culture in influencing trainee engagement with feedback.

INTRODUCTION

Feedback is recognised as a key component of learning and professional development for health professionals [1–7]. This has been particularly recognised within the competency-based model of training and in work-integrated learning context (e.g. workplace or proxy-workplace). However, the literature concerning feedback in health professional education is predominantly Western in origin, and there is comparatively limited discussion on how feedback is practiced in Asian Cultures. We are therefore asking what the experience of medical trainees is in a Southeast Asian city in terms of how feedback is provided, and how it may differ from the experiences in Western world.

We ask whether Culture influences how feedback is sought and used by trainees and what aspects of culture have an impact. Clearly, the term ‘culture’ has several facets that are potentially influential; it can indicate Culture in the wider ethnic sense, or the culture of the educational environment and even the cultural impacts of a country's colonial experience. This paper explores the trainee perspectives and understanding of feedback for their learning in the clinical environment, in Malaysia. (In this paper we will use ‘Culture’ and its derivatives with capitalised ‘C’ to signify the ethnic sense.)

Study Context

Malaysia

This study is situated in Malaysia, a multiethnic, multicultural country in South-East Asia, consisting of Peninsular Malaysia and East Malaysia. Peninsular Malaysia has borders with Thailand and Singapore, and is separated from Sumatra, Indonesia by the Straits of Malacca. East Malaysia is situated on the northern part of the island of Borneo, bordering Indonesia [8].

With a population in 2025 of 34.3 million, the county is comprised of 53% Malays, 11% Orang Asli and East Malaysian indigenous (Orang Asli = Original people of Peninsular Malaysia, 0.7%), 20% Chinese and 6% of Indian origin [9]. The national language is Bahasa Malaysia, while several languages are spoken by the Chinese population (Mandarin is taught in Chinese schools but other Chinese languages are spoken), Tamil is the dominant language of the Indian population, and English is widely spoken[10]. English is the medium of instruction in the University where this study was carried out.

Historical influences on Culture and the education system have impacted these trainees’ approaches to learning, and it is appropriate to briefly describe these. Malaysia’s history can be said to have begun with the Sultanate of Malacca around 1400 AD [11], although Chinese and Indian [12, 13] influences predated this. The Malacca Sultanate encompassed the East Coast of Peninsular Malaysia and Sumatra; Islam emerged as the major religion with the conversion of the ruler of Malacca. The Sultanate fell to the Portuguese in 1511 [11], beginning a long period of colonisation by Portuguese, Dutch (from 1641), and British (from 1841 to 1957), with a brief Japanese colonisation (1941–1945). During the British colonial

period Indian and Chinese people were brought to Malaysia to work in rubber plantations (Indian) and in tin mining (Chinese), under a 'foreign labour importation' policy [14].

The education system has its own overarching culture which influenced the students' experiences of high school. The education system's culture defines the school culture which in responding to the system added its own layer. The Malaysian education system has had an examination-oriented curriculum that is related both to the Confucian Heritage influence [15] and the education processes introduced during the British colonial era. It was suggested that the Confucian concept of learning which balanced learning and thinking, and learning and practice, was in fact misapplied when the Confucian classics became official texts for examinations and memorisation of the texts became emphasised [16]. Curriculum and examinations substantially influenced the experiences of Malaysian students during their time in high school and at the same time teachers also felt controlled by this. Idrus[17] reported a study with the introduction of 'culturally responsive teaching' into the classroom, and found teachers in the study resisted the program, not because it was felt unnecessary but because examination preparation demanded teaching time.

Ethnic Culture

Culture is recognised as a complex construct, with debate about the role of internal aspects such as beliefs or values, and external components such as artefacts, or institutions. Over time, many definitions of Culture and descriptions of components or dimensions of Culture have been suggested. Hofstede's dimensions have been widely used to study the influence of Cultural values on education in Asia [18–21] and we have elected to follow that lead in this study. Malaysia is conceptualised in the Hofstede dimensions as Collectivist, with a high power distance, and an element of uncertainty avoidance, and is more like Indonesia and China, and unlike Australia or Great Britain, for example [22].

Hofstede has used the metaphor of 'mental software' and has described Culture as:

The collective programming of the mind that distinguishes one group or category of people from another … culture is (a) a collective, not individual, attribute; (b) not directly visible but manifested in behaviours; and (c) common to some but not all people. [23](p.9)

Hofstede's dimensions framework was developed from data obtained in surveys of staff attitudes in subsidiaries of the IBM Company in 40 countries (with at least 50 respondents from each) between 1968 and 1973. Through factor analysis he described the initial four dimensions [24]:

1. Individualism – Collectivism (I-C): The extent that people in society feel independent (Individualism) or interdependent (Collectivism).
2. Power Distance (PD): The extent to which society accepts unequal power distribution.
3. Uncertainty Avoidance (UA): The extent to which a society is anxious about uncertain or ambiguous situations
4. Masculinity – Femininity: Assertiveness, acquisition vs. Care, quality of life.

Two further dimensions that were added later [25], and not based on the original dataset:

1. Long vs Short-term Orientation: The focus of people's choice towards the future, or current situations
2. Indulgence vs Restraint: Gratification, or control of wishes for enjoying life.

Hofstede pointed out that the Cultural dimensions are constructs, rather than existing in any tangible sense [26]. It is emphasised that the dimensions are not about individuals, but summarise Cultural aspects of national societies, and are certainly not means of stereotyping societies [21, 26, 27]. The dimension constructs have been criticised as simplistic and fixed and not considering changes in Culture over time. Dimensions of Culture are concepts to help understand the complexity of Culture [28–30]. The stability of the dimensions over time was confirmed and although changes had occurred, the relativity between countries had not changed significantly [31]. A recent study [27] compared medical students' and trainees' profiles from 16 countries using Hofstede's survey. While variations from Hofstede's data were noted they recognised clustering of countries. Uncertainty avoidance showed most variance in their data.

Feedback

Ramani et al [32](p.744) describe feedback as 'a vital cog in the wheel of competency-based medical education'. While earlier descriptions of feedback (such as those of Ende [33] or Hattie and Timperley [34]) characterised feedback as **telling** – information that was given to a trainee for performance development – recent models have placed the trainee at the centre of a dialogue. Existing literature is mostly grounded in Western educational contexts [1, 3, 5, 32, 34–43], leaving a gap in understanding the conceptualisation and utilisation of feedback in non-Western contexts, in particular for us in relation to Asian countries. We recognise that feedback processes may be shaped by both Cultural values and educational traditions that are different from what is seen in Western contexts. How is the development of clinical competence in Asian contexts influenced by differences in feedback practices arising from Cultural contexts? However, if feedback is seen as key to learning in clinical environments, we feel we need to ask what features of what culture support seeking, giving, and using feedback, and which hinder feedback processes?

We have recently completed a scoping review of literature from the broader Asian region to identify current understandings of the impact of Culture on feedback [44]. We noted that Culture (particularly power distance and collectivism) had significant impacts on trainee and supervisor understanding of the role of feedback in the clinical learning environment. Feedback was predominantly 'negative' and often punitive or humiliating. Healthcare and education system cultures influenced provision of negative feedback, or even lack of feedback. Across Asia, the perceptions of feedback of both trainees and their supervisors were marked by tensions and contradictions. We found little discussion about how feedback was used, and reflection did not appear to be acknowledged as important.

This research aims to identify:

1. how trainees understand feedback and its role in learning
2. approaches used to provide feedback in the high power distance, collectivist Cultures,
3. effective approaches to recognise feedback needs and encourage feedback seeking and use by trainees who grew up in such Cultures.

METHODOLOGY

This study was underpinned by interpretivism, which premises that reality is subjective and dependent on the individual's experiences and interactions with the social world. As researchers we aim to understand those experiences and interpret the meanings [45–48] behind what is told to us by the participants in the study. Aligned with this view we have employed Interpretive Description as our methodological approach. This is a flexible qualitative research methodology that originated within nursing and is useful in analysing experiential data from clinical and educational settings. Interpretive Description allows researchers to bring their discipline perspective and practical knowledge of a field to apply to complex human settings [49–51]. It provides a methodology for analysis which has an interpretive or explanatory flavour. It aims to synthesise and contextualise, going beyond just describing the patterns found in the data, to better understand [52] the complexities, in this case, of Culture(s) in medical education.

While there are several characterisations of components of Culture, the Hofstede classification (and direct modifications) have been used by others who have looked at Cultural impacts on health professional education in the Asian region, and we feel it has validity in thinking about Culture and feedback provision and utilisation. While the Hofstede classification originated as a 'positivist' (numerical) approach, it has broader relative descriptions that align more with our interpretive approach. We recognise that there are layers of cultures that potentially interact with these trainees' learning - the ethnic Culture, to which the Hofstede dimensions apply, the school and education system culture, and the effects of the colonial era culture including 'divide and rule' impacts.

Participants

This study involved fourth year medical trainees from a clinical school based in Johor Bahru, Malaysia. This is a privately funded medical school in Malaysia and is a campus of an international university. Fourth year trainees were chosen as they had completed three semesters of clinical teaching at the time of the study, and the main data collector (PDF) was able to withdraw from teaching responsibilities with this group of trainees. (PDF had a significant academic and administrative role with fifth year trainees making it impossible to withdraw from the role and presenting potential conflict of interest if final year trainees were involved in the study.) Trainees were informed of the study by means of notices placed around the clinical school and in tutorials; all were encouraged to attend a Zoom meeting where the study was explained in detail, after which they were invited to participate. Trainees were provided with a

written explanatory statement, informed that they could withdraw at any stage, and they then completed a written consent form if agreeing to participate.

Data collection

Thirty-five participated in the study out of a fourth year cohort 136 trainees (51 males and 85 females). Participants attended two, semi-structured group interviews; ten entry group-interviews were held in mid-2022 and eight exit-group interviews in three months later. Unfortunately, it was not feasible to ensure that the participants participated with the same groupings in both the entry (male 11: female 24, including 5 international to Malaysia) and exit (male 7: female 15, 4 international) group interviews. Interviews were conducted face-to-face, except one of the exit groups was held by Zoom as the participants were in isolation due to Covid. All participants were invited to submit diaries of their feedback experiences between their group interviews – 62 diaries were submitted by 24 participants (7 male and 17 females, including 4 international participants) with between one and five diaries being submitted by each of the participating participants. Most diaries were submitted in audio form although two participants elected to provide typewritten submissions.

The group interviews were audio recorded and transcribed using Otter.ai software, after which the transcription was checked against the recording and hand notes made at the time of the focus group meetings. Transcribed recordings were anonymised and these transcriptions were transferred to NVivo Version 15 [53] which was used in analysis.

Definitions

● Participants – the term is used to refer to the medical students participating in the study and will also include the students' comments and observations of junior doctors (house officers, recent graduates). We use the term trainees to refer more generally to this student cohort.

● Supervisors – includes academic staff (who participated in later interviews) as well as observations about more senior doctors who supervised the students and junior doctors in the clinical environment.

Data analysis

Data analysis was conducted using NVivo Version 15.3 [53] to systematically organise and code the transcriptions of the included interviews and diaries. Two authors (PDF and MS) independently analysed three sample transcriptions inductively to identify initial codes and compare with coding obtained in the scoping literature review. From these analyses, we developed an initial coding framework for the study data with input from the broader research team. The coding framework was iteratively refined through a series of team discussions so we could compare, contrast, and negotiate our interpretations. Author PDF then applied the agreed-upon framework to code the remaining transcriptions. Team consensus discussions were used when new or ambiguous codes were identified during this process and were integrated into the framework. Themes and sub-themes were developed based on the coding while regular team discussions allowed further refinement. Discussions focused on comparing interpretations

and resolving discrepancies, while considering the findings in the light of our scoping literature review on feedback and Culture. We believe this collaborative and iterative process enhanced the credibility and rigour of our analysis.

Team reflexivity

Our research team comprised four academics with diverse disciplinary backgrounds and demographics (e.g., age, gender, ethnicity). All members have prior experience conducting qualitative research, with three authors representing health-related disciplines (Nursing, Paediatrics, and Microbiology) and one a STEM (Science, Technology, Engineering, and Mathematics) education discipline. Each of us holds an academic position within a university operating across Malaysian and Australian campuses, and all have teaching experience in Asia and/or Australia. We were also shaped by growing up in non-Western contexts—Fiji (PDF), Vietnam (VN), India (VP), and Bangladesh (MS)—and by working across multiple cultural and educational systems.

These varied professional and cultural trajectories may have influenced how we interpreted feedback practices, particularly given our exposure to differing norms regarding hierarchy, communication styles, and trainee–teacher relationships. Such experiences could shape our assumptions about trainees' feedback behaviours. During research meetings, we purposefully questioned and challenged our own and one another's assumptions, values, and interpretive lenses.

The diversity within our team enriched the analytic process: contrasting perspectives prompted deeper interrogation of the data, broadened interpretive possibilities, and increased the methodological rigour of our analysis. Through discussion and collective reflexive practice, we aimed to remain attentive to participants' voices and ensure that our interpretations were grounded in the data rather than our preconceptions.

RESULTS

From the participant perspectives we identified the following themes:

- Trainee conceptualisation of feedback, and its utilisation in practice
- Trainee experience of feedback
    - Power distance, hierarchy and humiliation
    - Collectivism, Peer feedback and uncertainty

Participant Conceptualisation of Feedback: **How do participants describe and use feedback?**

Across the 18 group interviews conducted with participants, it was clear that their dominant conception of feedback was 'feedback as telling'. All participants regarded feedback as someone else's opinion of their performance although they described it as *'one of the most critical factors that influences students'*

performance.' (EntryFG_3, ¶25). Typically, they experienced critical or negative feedback more commonly than constructive feedback. However, the consensus was that negative feedback would be of value to improve performance after they could overcome the feeling of belittlement and had an opportunity to '*dissect*' what was said and could identify strategies to improve performance. Even humiliating, negative comments could be regarded as valuable feedback, if they could identify information that would assist them to improve their performance.

'[A]t the end of the day, the aim of the person giving the feedback is to help the other person improve. So, when it comes to negative feedback, as much as we hate to listen to it because it brings us down, I think it's up to us to decide and dissect into what they really say and take the parts that we think is useful to help us improve.' (EntryFG_5, ¶19)

Occasional participants commented that they valued continuity of feedback from a tutor who remembered previous practices or skills and provided comments on the progression of their performance, which they themselves found particularly motivating. For example, the following participant recognised the benefit and felt encouraged to continue developing their skills.

'One thing I realised today is that I would consider good feedback to have some form of continuity. The feedback I received was based upon previous feedback and performance. I felt that my tutor was invested enough to remember my shortcomings and to follow up on how I had progressed. This feedback made me feel especially determined to keep improving. Knowing that my tutors were looking forward to my improvement gave me a healthy push' (SD_CYY_1, ¶1).

In all the group interviews, participants identified their perceptions of what was *not* valid feedback. General comments without any further elaboration were not felt to be genuine feedback. A common concern was when adverse comments were made about the person rather than their performance, especially aspects that were not really under the person's control – for example, they sweated a lot, their gender, they were 'smiley', or when the tutor stated they 'hated silent thinkers'. Statements that the participant 'did great' or took a good history, without any further information about what aspects were done well and how to further develop was considered as unhelpful as criticism without advice about how to improve.

'[S]ometimes too little feedback, like just saying, Oh, you did good. You did great. It's also bad feedback, because you don't know which aspects of that class you actually did well, and it would be better to expand on what you did well.' (EntryFG_3, ¶46)

'[I]f you are just telling the person, I don't like your work, it's very lousy, it's not complete, it's not nice, but you are not telling the person, how should he or she improve. Then I don't think this is a good feedback' (EntryFG_5, ¶46)

Comparison with another trainee's performance was generally felt to be unhelpful if *'the feedback is mostly them comparing you to someone else.'* (EntryFG_5, ¶124). Equally, feedback at the start of a

rotation that was *'fixating on somebody not being good enough before they even had the chance to get more experience'* (EntryFG_5, ¶67), rather than providing advice, encouragement and time to acquire the relevant skills and experience, was regarded as inappropriate.

Participants compared their experiences in the medical school with their memories of childhood and especially during their school years. They regarded their early years experiences were more influenced by their Asian Cultures, and this had been modified since starting tertiary education, taking on Western characteristics. Frequent scolding was reported as being the norm from a young age, with punishment (and scolding facial expression) being readily recalled. '*The schooling system* [here] *makes you like a follower, not a leader. They just want you to obey the rules. Don't question the rules, follow the status quo'*(EntryFG_11, ¶172). Many participants felt that in school they were not encouraged to have an opinion, and for the most part no individual feedback was given, *'only a lot of scoldings'* (EntryFG_11, ¶166). On the other hand, several participants felt that the school culture made them more resilient and able to cope with scolding in the clinical workplace.

[It] '*really depends on the culture itself, like the culture of the surface, how he was brought up … since young. If he was being kind of experienced into those kind of reward-punishment system, then you might feel that this person may be more resilient towards this kind of punishment'* (EntryFG_02, ¶85).

Positive feedback experiences in school were unusual – however, one participant reported having a primary school teacher who would ask the class to exchange workbooks, to read and comment on a classmate's work, giving feedback with a system of *'two stars and one step - two things that were done well and one thing to build on'* (EntryFG_7, ¶34). Another reported some feedback during the school years that was described as neutral. Throughout their school years, the emphasis was on examination marks which promoted rivalry and competition – '*you feel happy when you get high marks, …, but at the same time, it promotes rivalry, competition, promotes unhealthy behaviours, promotes bad mental health'* (EntryFG_11, ¶235).

Experiences and Practice: **Power Distance, Hierarchy and Humiliation**

Malaysia is recognised as a high power distance Culture in the Hofstede schema. The power distance effect was seen both in the use of humiliation in teaching, and in a reluctance of trainees to question or provide feedback to their supervisors. As noted above, this had been inculcated from childhood, *'there is no such thing as feedback* [here]. *It's either you did something right, or you're wrong and people are scolding you'* (EntryFG_11, ¶154). Deference to your teachers is emphasised across all the Cultural groups, but was exemplified by one participant who reported,

'[I] studied in an Indian School. So, in Sanskrit, there is this thing called 'Guru devo bhava', and it's, it means like teachers are equivalent to gods. And it's kind of; it's kind of practised a lot through the schooling …' (EntryFG_2, ¶208).

‘Scolding’ was often discussed in relation to the learning environment, including in training hospitals. Scolding is typically defined as using harsh, coarse or abusive language; vituperation, angry reproach, reproof (Oxford English Dictionary, 2025). However, from the perspective of the study population, it is a widely used term in hospital environments, referring to interactions between a senior and a junior person usually in public and in a loud voice, perceived as humiliating or bullying.

Humiliation or scolding was reported by most participants as a common means of correction, particularly from senior doctors towards more junior trainees – but was less evident towards medical students. Humiliation appeared to be regarded as an efficient method to correct errors or inappropriate behaviours. Senior doctors felt they were helping to develop better doctors – as healthcare was about patients’ lives, they needed to be ‘strict’ to prevent future errors by their trainees! However, participants felt it was used to exert authority by frequently revisiting minor mistakes, such as writing notes in the ‘wrong font size’. Differences in approach to problems including following another specialist’s clinical management advice were frequently considered unacceptable. Some participants felt that scolding was simply a shortcut for the senior to indicate they could not be bothered – it was easier to just shout at the trainee.

Most of the participants in the group interviews had either experienced or observed humiliating feedback in the clinical teaching environment but recognised this had been the pattern of ‘teaching’ in hospitals for many years. They felt that their supervisors were teaching the way they had been taught during their training. This approach was often justified by both participants and supervisors as necessary because people’s lives were at stake. In a workshop organised by the trainee body discussing trainee mental health, a senior doctor was reported to say that current trainees were weak and that they should just accept harsh punishment as a means of learning – *‘today's students are weak. You're supposed to not take it to heart. You're supposed to take it, understand the meaning, and continue with life, not talk about it all day.’* (EntryFG_11, ¶226). This attitude mirrored the approach to teaching and learning experienced during their time at school. Many participants felt demotivated by this humiliation, while others felt that they had learnt over time to ignore the humiliation, attempt to identify areas for improvement, and recognise what they should continue to do in future.

‘[H]umiliating type of feedback, which I think is pretty common in our in our Asian setting, I mean, humiliating feedback can still be a good type of feedback if the content of it is actually constructive, but it would make the person who’s on the receiving end feel terrible for a period of time.’ (EntryFG_5, ¶49).

When participants felt their contribution to the discussion in tutorials or bedside teaching was acknowledged, even critically, they were prepared to continue to participate on future occasions, and felt their learning was enhanced. In these circumstances they recognised that they were also learning from the feedback on their errors.

‘[H]umiliation is how certain people say that's the way they have learned. And I believe that negative feedback … has been given more importance than good feedback. … [G]ood feedback is equally as

important as the negative ones, because as much as you want to know where you're wrong, you always also want to know where you're right.' (EntryFG_6, ¶40)

Public humiliation of trainees – junior doctors and medical students – was reported by participants to undermine their interactions with patients, and potentially patient care. Participants reported that they were despondent and doubted their capability, asking themselves, '*Can I graduate from medical school? Will I become a doctor that would help people instead of harming people?'* (SD_GTA_2). While the phenomenon of trainee suicide is not unique to Malaysia [54–56], several participants reported witnessing the way house officers were treated by their supervisors and found it unsurprising that suicides were occurring; they reported hearing supervisors tell trainees they were so bad they should go and jump off a building, and that any trainee who did so was just not fit to be a doctor.

'[The] superior will really just scold the Houseman in a very rude manner, like they call them 'monkey' in front of patient. They tell them 'you have no brain' in front of the patient. So how can you … how can you want the patient to trust the doctor after the superior has scolded him in front of the patient. (EntryFG_5, ¶157)

Bullying in the clinical environment often masqueraded as feedback and was conceded as appropriate behaviour – '*my senior bullied me, so I bully you …'* (EntryFG_7, ¶91). When participants were made to feel that they were simply not good enough, they reported a loss of motivation and a lack of engagement with the curriculum. This became a vicious cycle in that they recognised they were reluctant to make comments or ask questions and thus found themselves ignored by busy clinicians who described them as being lazy or not interested in learning. Effort was frequently directed to controlling their emotions, rather than learning from the experience. Several participants commented that following humiliation, they had little recollection of where they were deficient or what they needed to do to improve their performance; the sense of humiliation dominated their memory.

'… I chose to shut up and just listen to him, agree to what he had said. And it was a very frustrating and emotional experience to me. I was on the verge of crying, but I didn't. Yeah. And I actually spent a lot more time to control my emotions rather than to think what was going wrong in that whole consultation.' (SD_GTA_5)

While many seniors provided examples of behaviours that participants hoped they would not emulate in their futures as clinician teachers, some tutors were clearly seen as appropriate role models.

'[She would] observe, explain to us why and also show us the correct technique. Yeah, so basically, I just somehow want to follow her footsteps to become a better teacher like her to my juniors in the future' (SD_MN_1, ¶14).

In discussing feedback **to** tutors or supervisors, Power distance was evident. Upward feedback was described as equivalent to *'fighting God'*. Participants reported that they were reluctant to provide feedback to a more senior person (especially to their supervisors) because it was disrespectful and

culturally inappropriate. Even when it was requested, there was a general reluctance to give feedback to supervisors, and most would only give positive feedback. (The comment was made that if what they had to say was negative feedback, they would just complain amongst themselves.) There were exceptions when the feedback was anonymous, generic, or if they believed they had a good relationship with specific tutors and felt able to trust them. In the latter context, participants indicated that it still required courage, and that they would test the waters first. Occasional tutors were recognised as being different and were amenable to discussion and feedback.

'[It is a] bit difficult for me to give feedback to my tutors, because I would say that it's also a cultural issue at play. We grew up respecting authority figures, and we shouldn't talk back to authority figures. So, I would say it's difficult to give feedback to my tutors.' (EntryFG_11, ¶346)

Experiences and Practice: **Collectivism, Uncertainty Avoidance and Peer Feedback**

In a collectivist society loyalty to the wider social group (beyond the family) is considered essential to proper functioning of society. Relationships are generally strong and involve looking after the broader group, including preserving the 'face' of their peers. As was pointed out in one of the group interviews,

'[Our] Culture influences in a very big way. Because I would say Malaysia is, first of all, not a very individualistic country. So, we see things more as like a community thing.' (EntryFG_11, ¶148)

Group Feedback

Group feedback was particularly given at bedside teaching and participants recognised that feedback to the group was appropriate yet often vague. Comments such as '*You all have to improve more*' were considered non-specific by participants and were seen as a problem because it was difficult for individuals to identify which aspects of their own performance needed improvement. Conversely, group feedback on common or generic difficulties followed by comments specific to individuals was seen as appropriate, and was felt this would encourage teamwork.

While there was ambivalence about the place of group feedback, participants did recognise that there were benefits in receiving feedback as a group; they could learn from what other trainees were being told, and that it was an efficient use of the supervisor's time.

In *'teaching about this topic, she informed us about the questions to ask and points to add for patient education. Although this was not directed towards me, I thought that this was a good way to give feedback as well, as even though my tutor did not address all the feedback to me, it is understood that these are aspects that I need to work on and was delivered less adversely'* (SD_TZ_2).

They felt that group dynamics had a major influence on the acceptability of group feedback and impact on the trainees' face. Getting feedback in the group meant that trainees could learn by seeing the others' mistakes and '*even though you didn't commit these mistakes at that time, you might in the future, so it also is kind of a prophylactic measure'* (ExitFG_1, ¶68). However, at the same time it was recognised that

pointing out errors in front of the group was potentially an uncomfortable process for the whole group. This was influenced by both the words and non-verbal content of the feedback, group dynamics, discomfort of the person being critiqued and their own embarrassment of the peer's loss of face. Preserving face and maintaining dignity were considered important by participants. Critical feedback given to a small group was considered acceptable whereas criticism given in public was seen as an attempt to humiliate; in front of everyone it was *'spreading shame'* (EntryFG_05, ¶112). It was equally considered insensitive when someone else's work was compared with yours. When the bedside tutor '*compares someone's work to your work, I think that's a bit sensitive, because if I did something correctly, my colleague in the group did something not as good, she was like, oh, learn from X ... It's not good'* (ExitFG_5, ¶34).

Peer Feedback

Peer-to-peer feedback was encouraged especially during bedside teaching sessions, but perceptions of peer feedback were varied or ambivalent. Participants saw value in being asked (with forewarning) to provide feedback on their peer's performance in bedside tutorials as it required them to pay more attention to what their peer was asking while taking a history or doing in physical examination. At the same time, they recognised that usually they would only feel able to give superficial feedback, so relied on the supervisor's additional advice. Others felt that most of the time, their peers would be too polite to be honest or constructive in their feedback, preferring to avoid causing their colleague to lose face. '[Fellow] *students watching us during history taking, that in the end we get some superficial kind of feedback. Just taking care of the face of the person doing history taking'* (ExitFG_1, ¶203). Additionally, they saw little value in peer feedback as they were all inexperienced and learning. Peer feedback was considered to be pointless by many participants, and it was felt to be stressful in giving peer feedback in front of the supervisor; others welcomed it, appreciating honest feedback by peers prompted by their supervisor *'as I'm aware of my own poor performance, and I need an honest feedback for my knowledge and learning'* (SD_IV_1). While some participants recognised that there was a potential benefit to them and their peers in providing peer feedback, others expressed the view that the supervisors (not peers) were meant to be teaching them and therefore it was inappropriate for them to be asked to 'teach' their peers.

'Because technically when my colleague and I are with the tutors as teachers, both of us should be learning. I shouldn't be teaching, the teacher should be teaching us, right …' (ExitFG_6, ¶70)

Peer feedback was mostly considered acceptable when participants were practicing skills in self-study groups without a tutor present, although other participants expressed the fear that peer feedback was the blind leading the blind. In this context they tended to point out negative aspects of their peer's performance by commenting they would not do it that way but without suggesting a different way of doing things.

Conversely, observing peers during bedside tutorials to give feedback afterwards was described as *'an amazing learning experience for students to be learning how to give feedback'* (EntryFG_10, ¶268), and

helped them to become more observant; as a result, they improved their skills together.

'So, I think when you're looking at it from a third person point of view, that's how I would have done it but it kind of looks awkward, or kind of tough, then I guess you start thinking on how to improve as well. … So being able to look at someone else do what you probably would have done the same, I think gives us a bit more clarity on how to improve as well' (ExitFG_3, ¶121).

Being asked to provide feedback to peers was seen as a valuable means to learn how to receive and to give feedback, and in the longer term develop their ability to generate self-feedback. At the exit group interviews it was apparent that the participants were developing feedback literacy skills, at least in part because of providing peer feedback. Giving peer feedback was seen to help '*hone the communication skills because you have to bear in mind the way that you give the feedback to your fellow classmates'* (ExitFG_1, ¶191) to avoid causing a loss of face and out of a reluctance to identify errors outright.

Dealing with Uncertainty

An undercurrent of concern about uncertainty emerged throughout the participant group interviews and audio diaries. This was manifested by complaints about vague or ambiguous feedback comments that lacked suggestions for improving performance. The *'doctor said that your history is all over the place, and just left it as that'* (SD_TJH_1a). *'So, after that, I felt really incompetent. And the doctor didn't really gave more feedback and didn't even teach or answer what was the X-ray showing'* (SD_DL_1). A recurrent complaint was that many supervisors responded to questions by telling trainees they needed to think about it themselves, or they needed to go and read it up – participants wanted to be told the correct response. Conflicting advice from different supervisors was also unsettling –

'[Which] one is the correct way to do this. I feel that it's very confusing to have conflicting ideas. It's just that we need to, like make how to make a decision is to have a guide so that we know to meet' (EntryFG_02, ¶166).

Culturally derived uncertainty avoidance would appear to contribute to the desire to be told the 'right answer', that was reported by clinical participants. Uncertainty was approached by discussing with peers firstly, and only then approaching a selected tutor for further advice. In some classes, if a particular approach was queried the response was that the tutor did not care what another tutor had taught, it was *'my class, my style'* (EntryFG_2, ¶193). Often participants' solution was to ask colleagues who had been in a particular supervisor's group previously, how that person liked things done and then follow approach A in Doctor A's class, approach B in Doctor B's class and to attempt to prepare for clinical examinations with different methods to use depending on who ended up being their examiner.

'Some tutors have [a] specific way of doing it. So just for those tutors, we have to present our case in a particular manner but generally we have to present it to other tutors or doing our exams in a different manner' (ExitFG_07, ¶46).

Although it was more commonly reported that participants resisted uncertain or conflicting feedback and dislike for questioning in feedback, some recognised the learning value and engagement that resulted from speaking up, making mistakes, and from questioning and dialogue.

'He encouraged us a lot to speak up. And just to speak up as medical students, we should not be shy, we should be more proactive in that way. So that you can learn more. You can also [learn] from asking questions' (SD_EW_1, ¶8).

DISCUSSION

The participants in our study attended a privately funded medical school in Malaysia which is a 'branch campus' of an international university. They provided clear descriptions of the impact that Culture had on their experience of feedback in the clinical learning environment – particularly Power distance and Collectivism – as well as their hopes and expectations of feedback. At the same time, it was clear that the impacting cultures were a combination of (ethnic) Culture and the culture of the education system, interacting with each other. In line with what was noted in the scoping review [44], their experience was predominantly of receiving humiliating feedback, and the contradictions in their expectations were evident. Unlike the situation noted in the review [44] where reflection on feedback did not seem to be acknowledged as important, these participants did recognise the importance of reflection.

Feedback provision in high Power Distance, Collectivist Cultures

In this high power distance, collectivist Culture provision of feedback was predominantly *telling* and *error correction*, similar to what had been noted in our recent scoping review [44]. Feedback was commonly humiliating (generally referred to as 'scolding') and often lacked any indication of where trainees needed to improve. This was evident in the reports from our participants which mirrored what had been noted in a number of reports from elsewhere in the region [57–60]. Participants indicated that they felt able to accept negative feedback, even if it was provided aggressively, as long as they were given pointers to where their errors or deficiencies lay and how they could improve their performance going forward. Positive feedback was not valued if it did not provide an indication of what was appropriate and so could be continued or further developed. Positive feedback without such advice was seen as empty praise; this understanding of praise had parallels with the attitudes that were noted in the review (especially by supervisors [61] and by trainees [62, 63]). Praise that was primarily about the person, rather than the performance, was not valued in our context nor by trainees across the region [21, 64]. Scolding at its worst was loud, public, often protracted, and left participants wondering how they could approach those patients again; they even wondered whether they were fit to continue in medicine. The rationale frequently provided for this approach was that in medicine we are responsible for patients' lives and so errors were not tolerable; humiliation was felt to ensure the memory of the error would persist thus preventing future errors. Participants accepted that errors in medicine risked patients' lives, but conversely, reported that they frequently had little recollection of *why* they were being scolded,

remembering only the humiliation and their emotions at the time. This approach appears to reflect the supervisors' experiences in their own training, but current practices are said to be less severe than in the past. Supervisors appeared to be teaching the way they had been taught during their training. This mirrors the idea that this approach to teaching perpetuates harmful behaviours across generations of teachers, analogous to intergenerational transmission of child abuse [65, 66]. Anecdotally, this aligns with discussions concerning teaching by humiliation with senior doctors where a number have justified this in terms such as 'that's the way I was taught and I'm a good doctor,' along with comments about the risks to patient lives from medical errors.

Participants recognised that they were part of a collectivist society and that supporting their peers had a key influence on interactions in the clinical learning environment. However, while group feedback was appreciated to address common errors or misunderstandings, there was also a clear desire for individual, specific feedback that allowed them to address their own deficiencies or further develop where they were doing well. Generic comments to the group were not considered feedback, unless this generic advice was followed by specific feedback to individuals in the group; here, care was needed not to be excessively critical in front of the group. For these participants, group feedback was much less seen as a way of developing group aims than was noted by the trainees reported in the literature review [67, 68]. The group was usually the first port of call when faced with contradictory advice from different supervisors, and often the contradictions were only discussed further with supervisors if a clear consensus was not achieved by the group's discussions. There seemed to be little recognition that the whole group could have misunderstood a concept and that the consensus was therefore inaccurate.

Participants were ambivalent about the process of peer feedback. During bedside teaching peer feedback was used by many supervisors as a starting point and they would then summarise and add their feedback after the peer feedback had been given. Many participants saw advantages in being expected to provide feedback to a peer, forcing them to pay more attention to what their peer was doing, and compare that with how they would have performed a task. They were therefore able to improve their own clinical skills, as well as develop the new skills of giving and receiving feedback. However, they were fearful that they might not recognise a missed sign or incorrect technique by their peer and would be criticised for this; if they did point out errors, they were concerned about causing the peer to lose face. Others saw providing feedback to peers as being asked to teach their peers which they viewed as the supervisor abrogating their responsibilities – they were meant to be teaching while the trainees were there to learn, not teach. This coincided with these participants' dominant concept of feedback as **telling**, (aligning with earlier understanding of feedback, discussed earlier) and their desire to be given a single 'correct' answer.

Most participants participated in study groups with their peers where they would practice for OSCE examinations and review past examination papers. Answers to the past papers were memorised, often without recognising the principles underlying those responses. Participants frequently desired to be given the one 'correct answer' and reported that they were unhappy when alternative approaches were presented by their supervisors. Also, this contributed to a dislike of so-called 'Socratic questioning'. This

could be due to several factors – Culturally derived uncertainty avoidance, the use of single-best-answer, multiple choice questions in assessment, and experience of a heavily examination-oriented school culture that required exactly worded answers to questions. It raises concerns as a risk factor for clinical reasoning errors where nuances in patient presentations may mean there is no clearly 'correct' answer.

In a book first published in 1959, Edward Hall, an early cultural anthropologist wrote:

'Culture is a mould in which we are all cast and it controls our daily lives in many unsuspected ways. … … Culture hides much more than it reveals and strangely enough, what it hides it hides most effectively from its own participants.' [69] (p. 53)

This resonates with our participants who did not appear to recognise or attribute their concerns to the overlying Culture of their society, which exemplifies Hall's observations that individuals are often unaware of the impact their Culture has in shaping their perceptions [69](p.53). They did attribute some of their difficulties with feedback to their experiences at school, and as we will discuss in the coming paragraphs, the education system's culture was a product of both ethnic Culture and the effect of colonial policies and examination system. As mentioned, Malaysia comprises three main ethnic groups – Malays, Chinese and Indians. It is worth reviewing the historical perspectives of pedagogy of these Cultures as this impacts the interactions between education and Culture in Malaysia, while recognising overlaps between these pedagogies.

The Malay perspective of learning culture has its roots in Muslim pedagogy but influenced by the colonial education system [70]. Islam has a strong tradition in education, particularly in the first few centuries, although over recent centuries little has been written about Muslim pedagogy [71]. In the early years of Muslim scholarship there was a tradition of questioning [70], and pursuit of knowledge is seen as a religious duty [71]. Respect for the teacher as an authority figure inhibits challenge by trainees, although in principle there is no reason against interactive learning [71].

There has been much written about the influence of the 'Confucian Heritage Culture' of learning (CHC) on trainees from Southeast Asia as well as from China, Japan and Korea. Confucius wrote of learning as a means of social change and to overcome social differences but also placed much emphasis on personal effort [15]. Wang [15] highlights that memorisation was a precursor to understanding, and it did not lead to superficial rote learning (as has previously been stereotyped by many western educators). The learning schema was: *Memorisation → Understanding → Reflection → Questioning → Deeper Learning* [15]. Wang [15] sees parallels in Confucius' writings about education with Plato's 'philosopher king'. The Chinese / Confucian philosophy of education also highlighted a mutually respectful relationship between teacher and learner, with the teacher guiding the learner, rather than 'pulling the learner along' [72]. Here, memorisation was important but was memorisation-for-learning and not rote learning [16, 73, 74]. A study of Malay and Chinese adult learners found that, while there were differences, both groups had similar approaches to learning and tended to use an understanding and memorisation process for learning [75].

There is a parallel in the role of *guru* seen in the Indian culture of education – with the *guru* (teacher) nurturing the learner [76, 77]. Indian traditional pedagogy was community based, collaborative, encouraged shared wisdom and collective responsibility [78]. In the *Gurukul* system, a residential school with their teacher (*guru*), education was broad-based and oral, where students memorised knowledge, recited scriptures and received moral guidance and life skills [78–80]. Under colonial education students rote-learned material they didn't understand, in a foreign language (English), hoping for advancement [81]. As the British 'foreign labour importation policy' brought Indians to Malaysia, it is conceivable that this approach may have influenced Indian education in Malaysia at the time.

Overlying, and contributing to the influences of these Cultures is the effect of the British colonisation of Malaya. This significantly impacted the education system, with effects still seen today, more than 60 years after Merdeka (Independence). During the colonial era, education aligned with 'divide and rule'; schooling was segregated according to the economic needs of the colonial government and business [14]. The curriculum served the colonisers, rather than the learning needs of students [70]. Following independence changes were made to the education system to assist with forming a national identity in a system which '*seeks to harmonise between the western and the Islamic traditions of knowledge*' [82].

Identifying feedback needs and approaches for trainees

As alluded to earlier, we see that the 'ethnic' Culture and the culture of the school system both influenced participants' expectations of feedback. Feedback was not regularly experienced in the school system. Participants reported that in school, either their response was 'correct' and nothing was said, or they were scolded soundly. In an earlier study [83] participants reported that in school they were humiliated or even physically punished when they responded to a question in their own words, rather than the prescribed words used in the textbook – the most commonly provided example was for a compulsory subject, but other subjects were also indicated.

Identifying their learning needs and asking for feedback was viewed as a foreign concept for many of our participants from two points of view – 1) they felt this would reveal their deficits and 2) it was potentially disrespectful to their supervisors. Teaching by scolding or humiliation was recognised as having a long history both within the school education system and in hospital education, but they did not see it as conducive to their development as future clinicians. We recognise that Culture clearly impacts feedback provision and use, although these participants' understanding is consistent with older education literature where feedback was seen as telling [33, 34]. More recently, the concept of feedback evolved to feedback-as-dialogue, followed by recognition that active involvement of trainees is central to the feedback process (as in Boud and Molloy's Feedback Mark II) [84, 85], and the linking of feedback with coaching [86–91]. This evolution has not been readily recognised by these participants, nor it would seem, by many of their supervisors. Feedback-as-dialogue was recognised as valuable by a few participants, particularly when there was continuity with a particular supervisor. We see a clear need to assist our trainees to develop their feedback literacy, to be able to identify their learning needs and goals, and work with their supervisors to achieve those goals. This will require changes on the part of supervisors and their approaches to providing feedback. It has been pointed out that good sports

coaches will push their protegees to the extent that they ‘fail’ and learn from that failure [91]. This is a concept that is generally difficult to accept in a healthcare learning environment because of the risk to patients and will be more so in an environment where teaching by humiliation is justified on the grounds of preventing risk to patients. Simulation is certainly one method that allows for errors without direct patient risk and probably should be used more

Incivility in Health Professional Education

Participants involved in this study highlighted their experience of ‘scolding’ (incivility or humiliation) in their learning environment and the hospital workplace. This has been supported on the grounds of patient safety, as a part of Asian Culture, and the way their supervisors had been taught, thus making the supervisors good doctors. From this study and our previous literature review we would argue that Asian Culture teaches respect for teachers, but this does not extend to incivility to learners. As highlighted earlier, the Chinese heritage philosophy of education supported a mutually-respectful relationship between teacher and learner [15, 72], the Indian philosophy highlighted the *guru* (teacher) as nurturing the learner [76, 77], and in Islam a strong and caring relationship between teacher and learner is emphasised [92–94].

Bullying and incivility in health professional education is certainly not limited to Malaysia or indeed to Asia. Literature from around the world indicates that this is an issue from South America (e.g. Brazil [95], Africa (e.g. South Africa [96, 97], Nigeria [98], Europe (e.g. UK [99–101], Greece [102]), USA/Canada [65, 103, 104], Australia/New Zealand [105–107], as well as Asia. Should we be concerned about how these experiences affect our trainees, or are such challenges simply an inevitable part of their education? We accept the evidence arising particularly over the past 20 to 25 years that this does indeed present dangers in healthcare. From a patient safety perspective, dangers include errors in patient care, loss of empathy, and problems of professionalism [108–112]. Dangers occur for trainees by way of dropping out from medical school, or resignation from hospital work [66, 105], and suicide. For the healthcare workforce, bullying has impacts on trainee choice of specialty [106, 113], contributing to maldistribution of specialties and healthcare staffing shortages.

IMPLICATIONS FOR PRACTICE

There are implications for the clinical school involved in this study, with regards to the need for development of feedback literacy and the understanding of adult learning principles. Implementation will require consideration of local sensitivities and aspects of Culture. We suspect that in the light of the findings in the scoping review [44], we are not alone.

Feedback literacy

In our scoping review [44] we concluded that humiliating feedback did not enhance trainees’ learning despite a widespread belief that it was key to trainee learning, protected patients from medical error, and prepared trainees for practice as health professionals. In this study, participants reported experiences that aligned with many of the findings from the review. A combination of the influences of a high power

distance, collectivist Culture, an education system influenced by colonialism, along with the experiences of supervisors during their training has perpetuated the idea for these participants. For many of these participants humiliating feedback was perceived as bullying and was generally not accepted as genuine feedback, while others (reluctantly) accepted it, if advice for improvement was provided along with the humiliation. We identified that most participants had limited feedback literacy and largely regarded feedback as telling. We suggest that they would benefit from training to develop that literacy, while respecting appropriate Cultural understandings. Based on the participants' perceptions of supervisor attitudes to feedback, we suggest that any training regarding feedback literacy should include supervisors so that feedback goes beyond just telling or dialogue, to helping trainees identify their training needs, the means to address the needs, and to identify their progress. Genuine feedback goes beyond the current dominant practice and is more than simply telling trainees what had been performed inadequately.

Adult learning principles

Aligned with uncertainty avoidance and power distance is the common reluctance to engage in discussion of their understanding or diagnostic thought processes and the desire to be 'taught' a single correct answer. When participants object to giving peer feedback in the presence of a tutor—believing that it was 'teaching', and teaching is solely the tutor's responsibility—they may be demonstrating a limited understanding of adult learning principles, which emphasise shared responsibility and active participation. Reluctance to engage in peer feedback appeared to result from a concern about loss of face – being criticised for missing a peer's error (their own face) and needing to point out the peer's error (peer loss of face). Others saw benefit in developing their own clinical skills and their ability to give feedback. We need to develop our trainees' understanding of adult learning and their tolerance of ambiguity, especially as ambiguity and uncertainty is a feature in clinical decision making [114–116]. In considering the development of our trainees' tolerance of ambiguity, we note that there is very limited literature on tolerance of ambiguity and uncertainty in clinical decision making outside Western countries [117, 118]. As practitioners, we recognise that clinical practice in healthcare is often characterised by uncertainty, and indeed tolerance of uncertainty has been described as a medical graduate competency [116].

STRENGTHS AND LIMITATIONS

Our study contributes further insights into clinical years trainees' experiences with feedback in a Southeast Asian medical course, thereby adding to the body of literature on feedback in health professional education in the region. By focusing on this Southeast Asian context, we draw attention to cultural influences such as hierarchy (power distance), collectivist values, and uncertainty avoidance on feedback practices that are currently underrepresented. While recognising that a discussion of Culture can be seen as stereotyping, our findings assist understanding of how local Cultural factors may shape feedback and trainee development, with potential implications for both regional and international educational practice.

The most obvious limitation to our study is that it was conducted in the clinical school of only one university in the region, where the medium of instruction is English. Most trainees were privately funded (although a substantial proportion received government scholarships) influencing the socioeconomic status of the participants. This may limit the application of our findings to other medical schools, especially where teaching is in the national language. The findings may be more generalisable if the study could be repeated in other health professions schools that include publicly funded institutions and where the medium of instruction is a language other than English.

CONCLUSION

The participants in this study reported a recognition of the importance of feedback to their learning but generally understood feedback as **telling** and error correction. They reported both experiencing and observing feedback being given in a harsh manner, but most accepted that approach as valid, as long as they were also given advice about how to improve or correct the errors. Malaysia is a country with a high power distance and collectivist Culture; this appeared to impede feedback seeking behaviours by trainees and made them reluctant to discuss or question feedback given to them. Peer feedback was often used in bedside teaching but was regarded with ambivalence. They were unsure about the validity of peer feedback because peers would potentially overlook errors to avoid causing a loss of face; a peer did not have the seniority or experience to critique. On the other hand, providing feedback to peers was a useful experience in that trainees needed to pay more attention to their peer's performance, and some felt it was useful training for them to give feedback in their future careers. Multiple cultures appeared to be at play – the education system culture and workplace culture appeared to interact with ethnic Culture in influencing trainee engagement with feedback.

Declarations

Ethics approval: Ethics approval granted by Monash University Human Research Ethics Committee (MUHREC) – Approval 27370. This study was conducted following Australia's NHMRC National Statement on Ethical Conduct in Human Research, which aligns with the Declaration of Helsinki.

Participant Consent: All participants provided written consent, after being provided with verbal explanation, a written explanatory statement, and were informed that they could withdraw at any stage; they then completed a written consent form if agreeing to participate.

Consent for publication: Not required

Availability of data: Data available from the corresponding author upon request.

Competing interests: None

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Authors' contributions: PDF conceived the initial idea for the study in collaboration with MS and it was further developed with VN and VP. PDF collected the data. Data coding was initiated by PDF and MS and continued by PDF with group discussion and analysis of coding as it progressed. PDF wrote the draft report which was refined by all authors. All authors agree to be accountable for all aspects of the study. PDF is guarantor.

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