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TITLE PAGE

Title: An exploration of how Malaysian medical students completing a partner medical school programme develop their understanding of the ethical dimensions of practice

Abstract

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Ethics is a significant topic within medical and other healthcare undergraduate curricula. Advances in technology, changes within our population, e.g. an increasing ageing population, those living with disabilities and chronic conditions, and increasing demands on resources have resulted in an increase in the ethical dilemmas experienced within healthcare practice. The globalisation of medicine and the increased mobility of students and professionals has resulted in a need to explore their understanding of ethical issues inherent to the clinical area.

This research seeks to address how Malaysian medical students on a partner medical school programme understand the ethical dimensions of practice, by focusing on the processes through which this understanding develops, the factors that influence this and what the participants' understand by the ethical dimensions of practice

A qualitative approach to the study was adopted, as it concerns itself with the feelings and personal experiences. An interpretive methodology was applied as this paradigm is concerned with understanding the world from the participants' perspective, and how "human beings make sense of their subjective reality and attach meaning to it" (Weber 1964).

A purposive sample of 16 Malaysian medical students in the final year of a partner medical school programme participated. Data was collected using a mixture of semi-structured focus groups and individual interviews. Interviews were transcribed and analysed using a descriptive phenomenological analysis based on an adaptation of Hycner's (1985) model of thematic analysis.

Key findings reveal that students develop their understanding through observed practices and patient interactions. The unique experiences offered by the partner medical school programme, such as placements in two distinct settings, influence the development of their ethical understanding. Students exhibited uncertainty and cognitive anxiety when ethical issues arose in practice. The relationship between the factors which influence the understanding of the ethical dimensions of healthcare and cognitive anxiety creates a cycle of reflexivity, leading to students developing their ethical sensitivity.

Existing literature suggests that ethical sensitivity is related to achieving ethical competence and a reduction in moral distress amongst clinicians, as well as enhancing patient wellbeing. Within the current globalization of medical education, and the increase in international students and workforce, there is a fundamental need to explore the students' experiences and perspectives on how they develop their ethical understanding whilst undertaking a partner medical school programme, as there is currently a lack of research in this area. The findings reveal the development of ethical sensitivity through the interrelationship between factors influencing students' understanding of the ethical dimensions of practice and the cognitive anxiety they experience during this process.

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on September 2011, Northwest NHS Research Ethics Committee on 8th December 2011 and Local NHS Trust Research and Development Ethics Committee on 5th April 2012.

I declare that the Word Count of this Thesis is 83,700 words

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Chapter 1

Background and introduction to the thesis

The turn of the 21st century has witnessed an unprecedented internationalisation of medical education due to global economic and social change, which has increased the mobility of medical professionals and students. Although travelling for the purpose of education is not a new concept, the implementation of partner medical school programmes (PMSP) is a new phenomenon in medical education. This has resulted in medical students being exposed to many different practices and philosophies when they complete their education in different countries. Yet, understanding of the experiences of students and the related outcomes has not kept pace with changes in the way medical students are taught.

The benefits of international students being enrolled within universities have been well documented. PMSPs offer a unique experience for medical students to complete their medical degree in universities in two countries, each for half the duration of the course. However, unlike well-established international programmes such as ERASMUS (European Region Action Scheme for the Mobility of University Students), PMSPs have not yet been researched and evaluated.

This study offers an insight into the experiences of Malaysian medical students who complete their education in both Malaysia and the UK, and focuses on their understanding of and engagement with the ethical dimensions of practice. Different professions within healthcare have a code of practice or ethics guiding their conduct to meet the goals and duties of the

profession (Vallent & Grace 2016), with the ethical dimensions of practice forming part of these professional codes.

Why this topic was chosen as a study

My interest in the exploration of this topic was multifactorial. As an overseas student having previously completed a healthcare degree, I felt a personal connection with the subject matter. My professional experience as an educator lies in the field of medical ethics and communication studies. I provide lectures and facilitate sessions on clinical communication skills and medical ethics to medical students in years 3-5 of an undergraduate medical programme within a UK university, which includes students on a partner medical school programme. The main challenges faced are often related to objective structured clinical exam (OSCE) assessment, in which students' ability to negotiate an ethically-challenging situation is assessed in a simulated scenario, using the knowledge and skills they have acquired during the medical course to arrive at an appropriate solution. Students are aware that they will be asked questions about ethical dilemmas within the examination process. However, students completing a PMSP often seek guidance on how to best answer those questions, wanting to know what the "right" answer would be, although when encountering ethical dilemmas there may not always be one answer, thus requiring one to negotiate solutions and make appropriate decisions. This sharpened my curiosity about the experiences of these particular students.

The literature suggests that two points of view exist regarding the purpose of teaching medical ethics: (1) that it is a means of creating virtuous physicians; and (2) that it is a means of providing physicians with a skill set for analysing and resolving ethical dilemmas. This dichotomy makes it difficult to arrive at a consensus regarding the goals of medical ethics education (Eckles et al. 2005). According to Singer (2000, p. 282) the goal of medical ethics is to improve the quality of patient care by identifying, analysing and attempting to resolve the ethical problems that arise in the practice of clinical medicine.

Ethical issues and dilemmas are inherent in medical practice across the globe. An understanding of how students on PMSPs develop their knowledge and understanding of medical ethics is important within the current context of the globalization of medical education. There is a need for research into medical ethical cultures in underreported countries (e.g. Malaysia), and specifically in medical education. Current research is beginning to explore differences in medical ethical culture within the growing context of globalization of healthcare, highlighting the importance of improving cross-cultural understanding in successful international medical collaboration (Grol-Prokopczyck 2013). The literature within postgraduate studies, however, reflects the challenges faced by overseas doctors in adapting to working in the UK, with ethical issues being highlighted as one of the main challenges. In addition, Hindmarch (2005) discusses the needs of the international workforce in medicine and how healthcare institutions can aid in the transition for overseas graduates into the UK workplace.

I approached the focus of the research from an educator's perspective, with a specialist interest in healthcare ethics. Having had experience of working with students from varied cultural backgrounds, including Malaysian students, I became increasingly interested in the impact of the globalisation of healthcare education, particularly the need to explore what influence this has on the students' understanding of the ethical dimensions of practice. Rothwell et al. (2013) discuss the needs of the overseas workforce in their transition to working in the UK, but there is little research on international medical undergraduates in the UK. Arguably, understanding this aspect of international medical undergraduates would be a step towards aiding their transition into the workplace.

The student population

In years 3-5, students from a local UK medical school enter the clinical phase of their medical course and their education is transferred from the university to a local NHS hospital affiliated with the university. The student cohort at the local hospital consists of approximately 80-90 students per year group, and is comprised of both home and international students. Some members of each student cohort are registered on a partner medical school programme. Of each cohort, 5-12.5% are Malaysian (between 4 and 10 students). Other international students include those from the USA and Canada (approximately 2-3), as well as European students (approximately 4), and those on ERASMUS programmes (between 2 and 4 students). The ERASMUS scheme is a student exchange programme initiated in the 1980s, allowing exchange students in Europe to access universities within Europe. Collectively, the overseas students make up approximately 13-26% of each cohort of 80-90 medical students (Table 1).

Table 1. Number of students in each category within a cohort of medical students at a local hospital

	Total Cohort Number	International Students	ERASMUS	European Students	Malaysian (IMU)
	80-90	2-3	2-4	4	4-10
Percentage of total cohort	13-26%	2.2-3.75%	2.2-5%	4-5%	5-12.5%

International students in the United Kingdom

International students are commonplace in the United Kingdom and its universities. Statistics from the UK Council for International Student Affairs (UKCISA) for the academic year 2015/16 show approximately 36,000 international students across UK universities, out of a total of 2,280,830 students on all undergraduate and postgraduate programmes, thus accounting for approximately 1.6% of the overall student population (HESA 2017).

There has been a lengthy history of travelling from across Europe to the UK for medical education. In medieval times, European universities were expected to attract scholars from further afield than their immediate country or province. Bologna was an example of this, and by the 12th century it had an increasing number of international students, as it was one of the few universities in western Europe to have a medical school. Such institutions attracted interest from students further afield, who wished to study medicine (Trueman 2015), and students were encouraged to travel both by the political drive of their home country as well as religious imperatives (Perraton 2014).

As in medieval times, there still exists kudos in studying at particular universities in the 21st century (Tulloch 2001), and Minsky (2016) highlights that students who attend top-ranking universities feel that they benefit from the reputation of the institution. However, it is a competitive system and entry requirements are strict, with universities limiting the number of international students on medical courses, dependent on the capacity of the medical school. In the academic year 2016-17, the University of Nottingham (which is involved in a partner medical school programme) accepted 150 international students, out of 330 students, onto its medical degree course, with the

highest number of entries being from Thailand and Malaysia respectively. In contrast the University of Manchester accommodates approximately 50 international students per academic year group of approximately 450 students (UoM 2016). International students travel to the UK for their studies, viewing the British higher education system as delivering excellence (Espinoza 2016).

International students bring with them knowledge, culture and social experiences which they can share with other students, thus enriching the experiences of others (UoM 2016). Although international students generate a substantial income for the cities in which these universities are based, it is also favourable for a university to attract the best students onto their courses, thus raising the academic profile of the university.

However, recent years have seen a limit placed on the number of international students accepted into UK universities, in an attempt to increase the opportunities for home students to access higher education and with a view to universities having programmes which rely less heavily on international students (Gil 2015). In addition, tighter immigration laws have meant that applications from international students have reduced (Houlder 2016). This has seen a reduction in the number of Malaysian students entering the medical degree in clinical years as part of the partner medical school programme at the UK university within this PhD study, and in turn a marked decrease in Malaysian students at the local base hospital. In addition, the potential increase in tuition fees for international students may deter prospective students from applying to the UK. This could potentially affect the partner medical school programme by only being accessible to students from the wealthiest families and could increase the competition for government scholarships.

International Medical University in Malaysia (IMU)

The International Medical University (IMU) was founded in 1992. It is a privately-run, English-speaking institution based in Kuala Lumpur, with campuses across Malaysia. It is the main institution in Malaysia for the provision of medicine and other undergraduate healthcare courses such as nursing, pharmacy and dentistry, as well as offering postgraduate and doctoral courses. IMU was the first to introduce a transfer credit scheme with international universities, and has affiliations with 30 universities worldwide, with a number of them being in the UK.

The partner medical school programme

The partner medical school programme (PMSP) was introduced at an international level in 1992 by the IMU, when it was originally partnered with five universities globally. That number has grown significantly and in the UK alone, there are connections with Manchester, Aberdeen, Glasgow, Liverpool, Nottingham and London Universities. Other partnerships exist with Australia, New Zealand and the USA (IMU 2013).

IMU describes its medical programme as consisting of 2 phases – phase 1 is pre-clinical, while phase 2 is clinical and offers students the option to undertake the clinical years either at IMU or at one of its partner medical schools (PMS). The option of attending a partner medical school aims to enhance the quality of the educational experience. It offers students the benefit of studying at home and abroad, whilst enabling them to attain a medical degree which is internationally recognised. This further allows students to complete their foundation programme training and register with the General Medical Council (GMC) in the UK, allowing them to practice medicine internationally.

University partnerships are mutually beneficial and considered to provide benefits to staff or students who wish to study internationally. These partnerships also make a significant contribution to the internationalisation of the institutions' objectives (Alexander 2013). The British Council's Erasmus Plus programme requires universities to fulfil 3 key action points; the mobilisation of people to improve and develop skills, thus increasing their employability; co-operation for innovation and exchange of good practices; and supporting policy reforms with a view to modernizing education and training systems (British Council 2017).

PMSPs are one of a variety of initiatives which higher education institutions have introduced as a way of coping with the global academic environment; others include universities having branch campuses overseas (Altbach & Knight 2007). The internationalisation of education does not solely include the mobilisation of students and staff but has also resulted in the global distribution of teaching programmes (Kehm & Teichler 2007). However, coping with the global academic environment includes adjustments to meet the needs of the international student population. Understanding the needs and challenges of international students will enable educators to aid these students in achieving their learning objectives. Cultural sensitivity and consideration of the impact on learners is particularly pertinent in the global export of educational programmes which may challenge cultural norms. These are issues that are consistent with this research study, especially within the field of medical ethics.

Achieving a medical degree from Malaysia presents some limitations in the practice of medicine globally, as it requires alumni to meet specific levels of competency in order to practice in each different country. The PMSP increases the potential for working internationally to prospective students, as it enables students to work as junior doctors in the UK and register with the GMC. This registration allows them to practice medicine globally and thus increases their employability and choices of where to work. Thus, this does

not solely benefit the students, but provides the institutions with a commercial advantage, as well as enhancing knowledge, language acquisition and the curriculum (Altbach & Knight 2007; Alexander 2013). However, Andrade (2006) challenges the recruitment of international students simply for the economic gain of the institution and recommends giving considered thought to the experience and achievement of learning objectives of these students. Teichler (1999) expresses that international education programmes are financially vulnerable, as fluctuating student numbers due to global political issues and varying student demand affects their long-term strategic planning due to a reduction in tuition fees. Institutions therefore need to be well-prepared to receive international students in a competitive academic climate (Universities UK 2014). Andrade (2006) further recommends implementing measures for adjustments and the interaction of home and international students to enhance the learning experience. The presence of international students, according to Ward & Kennedy (2001), enhances the curriculum through challenging educators to consider new methods of teaching whilst bringing an international perspective to discussions in the classroom. While there is little literature to debate the challenges of PMSPs, there is literature which brings into question the positive influences that international students bring to an institution. The expectations of international students are not often met by host institutions, with a lack of integration with home students being a key issue for international students. Within the learning environment, appropriate adaptations are not often made to accommodate the learning needs of international students, thus resulting in a less positive student experience. Teichler (1999) warns of issues of nationalism and chauvinism based on trends, attitudes and values towards international visitors that can impact on students' experiences. Although these sources are not focused on PMSPs, the similarities are transferable due to the globalisation of medical education.

An outline of the medical curriculum

The PMSP completed by the participants of this study included 2.5 years (5 semesters) at IMU, and 3 years (6 semesters) at the partner medical school in the UK. The diagram below provides an outline of the content of the programme completed by the participants.

Figure 1. Diagrammatic representation of the medical curriculum for students on a partner medical school programme

Semester / Year	1	2	3	4	5	Point at which students commence at the partner medical school	Year 3 Semesters 1 &2	Year 4 Semester 1 & 2	Year 5 Semester 1	Semester 2
Module Title	Foundation Programme*						Heart Lungs & Blood Nutrition, Metabolism & Excretion ^	Families & Children/Mind &Movement ^		Consolidation
Content	Anatomy Physiology Biochemistry Pharmacology Community Medicine Clinical Skills	Cardiovascular and Respiratory systems and Haematology	Gastrointestinal Renal and Endocrine systems	GP Placements Reproductive, Musculoskeletal and Nervous System. Basic Life Support Clinical Rotation/Elective	Community Health Survey Clinical Integration – placement/clinical skills/seminars and forensic science		Cardiovascular, Respiratory, Gastrointestinal, Renal and Endocrine systems and haematology Haematology Clinical Placements Clinical Skills Problem Based Learning Communication Skills	Obstetrics Gynaecoloy Paediatrics Neurology Orthopaedics Psychiatry Clinical Placements Breaking Bad News	Simulation Clinical Skills Lectures Work Based Assessments Exempting Exam End of Life Care Negotiating Solutions	Student Assistantship Elective Work based Assessments Final Exams

Presentation of study to raise awareness amongst students

Recruitment of participants

Interviews

Relevance of ethics in medical education

In the last 25 years, consideration of medical ethics has received formal recognition within undergraduate medical degree programmes. According to Mills and Bryden (2010) the teaching of medical ethics has become more prominent in undergraduate programmes since the 1998 consensus statement by the Institute of Medical Ethics' Education Steering Group (Stirrat et al. 2009). However, an agreed method of teaching the transferability of ethical decision-making from the classroom to the clinical area is still to be reached. Evidence suggests that putting ethical behaviour into practice offers a significant challenge to a newly-qualified doctor when developing ethical decision-making skills, and thus more needs to be done at an undergraduate level to help combat this challenge (Mills & Bryden 2010). Gillon (1986) describes this as a move away from earlier approaches, where students were expected to view their clinical teachers as role models:

> *I was told that it basically boiled down to doing as my teachers did and told me to do* (Gillon 1986, p. 17).

Learning behaviours through role modelling is flawed, however, as it is dependent on the role models being upstanding members of the profession. Roberts et al. (2006) concluded that formal ethics teaching would help medical students and clinicians in:

> *…learning to handle practical ethics issues and developing one's professional identity as a physician are essential steps in becoming a good doctor* (Roberts et al. 2006, p. 8).

Sokol (2007) shared the view that both medical students and junior doctors would benefit greatly from formal ethics teaching when:

…facing the many ethical issues they will encounter in their work, from telling patients the truth to managing the limits of their own competence and addressing the inappropriate behaviour of colleagues (Sokol 2007, p. 545).

Over the years, advances in medical science, such as those in reproductive technologies, have brought with them a new set of challenges that have rocked the foundations on which medicine was based, and those set in the Hippocratic Oath. It is due to these advances and future challenges that medical ethics education is required within medical curricula. This is based on the assumption that this will enable students to develop a level of ethical competence that will facilitate their ability to negotiate ethical dilemmas within their professional practice.

Medical ethics and the globalisation of medical education

The globalisation of medical education includes the export of education programmes, as well as staff and students. As medical education continues to grow on the global stage, so do the challenges brought about from introducing programmes which differ from and conflict with the beliefs of the cultures where such programmes are exported. Further to this, receiving international students into a higher education institution may also challenge the beliefs and values of these learners.

Authors such as Iserson et al. (2012) and Turner (2003) call for cultural sensitivity with regards to medical ethics. According to Miyasaka et al. (1999), medical ethics curricula are designed within an Anglo-American context and thus do not meet the needs of students from Asian backgrounds. The content of the medical ethics programme may not be transferable to their social contexts, thus impeding their engagement with the content of the programme. The challenge therefore lies within developing medical ethics programmes that are suitable for learners from a variety of cultural backgrounds and transferable to various social contexts. However, at present, there is little consensus on how to approach the delivery of medical ethics within the global education context, as discussed by authors such as Drane (2016)

and Chattopadhyay and De Vries (2008). This in turn poses a challenge to attempts to develop ethically competent practitioners within the global medical system.

The Malaysian context

Key influences in Malaysian demographics

The geographical position of Malaysia has attracted the settlement of major Southeast Asian populations and has become recognised for its diversity, having had a very complex history (Cheong 2006) with settlers including the British, Dutch, Portuguese, Indians, Chinese, Japanese and Arabs. The population of Malaysia consists of Malays, Chinese and Indians as the 3 largest ethnic groups. Malaysia is an Islamic country, having converted to Islam from the Arab communities in the 14th century. Whilst Islam accounts for 61.3% of the population, the remainder is made up of Buddhism (19.8%), Christianity (9.2%), and Hinduism (6.3%), alongside Confucianism, Taoism and other traditional Chinese religions (1.3%) (Indexmundi 2018). Hence there are numerous influences within this population, and the development of individuals' personal philosophies.

The impact of these people and their cultures plays an important part in the perception and management of disease, influencing the provision of healthcare. Values and norms may vary between cultures, and a variety of cultural health beliefs and practices are evident within these ethnic groups. A doctor's understanding of these cultural beliefs aids patient care through improved diagnosis, treatment and patient engagement (Ariff & Beng 2006).

Malaysian healthcare system and regulation of professionals

Malaysia operates a mixed economy healthcare system, which offers both state and privately-run hospitals, but patients are expected to pay a nominal fee when they require the use of the health service (Quek 2014). However, due to the diverse

nature of the populations, there are allowances within the health system, designed to meet the healthcare needs of specific populations such as the Indian Aborigines who are unable to access mainstream healthcare in larger cities. These programmes are state-run, and patients are not required to pay for the care provided. Variations exist between city and rural hospitals, often with regards to the size and number of services provided (Quek 2014; AIA 2017).

The Malaysian healthcare system is administered and regulated by the Ministry of Health, for both the public and private sector (WHO 2012). Professional legislation for practice is regulated by the Malaysian Ministry of Health through the implementation of the Medical Act (2012) and Medical Regulations (2017) (Lau 2017). The Malaysian Medical Council (MMC) is the professional regulatory body, whose duty is to promote the safe practice of medical practitioners and ensure public safety, in accordance with the Medical Act (MMC 2017).

Potential for ethical dilemmas

Working within the diversity of the Malaysian population has potential for ethical dilemmas based on the varying beliefs and values that each social group may hold. It is also worth considering the position of medical practitioners, whose cultural/religious beliefs may not align with those of the national religion and thus may be in conflict with the proposed guidance, as well as the potential varying beliefs about healthcare found within the various ethnic groups. This can be translated into the educational setting, whereby students' values and beliefs may differ from those of the country in which they study, the home students they are attempting to interact with, the educators they are learning from, and the patients they are caring for. However, students of Malaysian background have a great degree of respect for those in authority and do not expect to contradict their teachers (Ward 2001). Thus, there is a potential for students to feel conflicted by having differing views to their tutors, but these may not come to light due to their perceptions of the position of teachers. In addition, their learning needs may not be met, as educators are unaware of their ideas and understanding of the ethical dimensions of practice.

For the purpose of this study, the term *Malaysian student* refers to students who were born and had lived in Malaysia for most of their lives before entering the International Medical University. The study focused on individuals whose first experience of the UK was at the point of entering the medical programme in year 3. Students who attended IMU but were not of Malaysian origin would have had different experiences that may have influenced their understanding of ethics and how they approach moral dilemmas that arise in clinical practice, and so were not included in the study.

A summary of the thesis chapters

Chapter 1 – Introduction

This introductory chapter has briefly addressed the history and relevance of ethics within medical education, together with an overview of the programme completed by the participants with a view to providing a backdrop to the thesis. In addition, the history of international medical students in the UK and the origins and policy surrounding partner university programmes has also been presented.

By providing an introduction to Malaysian society and its health system, this chapter aims to bring context to the lived experiences of the participants of this study. This population has not previously been the focus of research, and thus my study offers unique insight into this population by exploring their understanding of the ethical dimensions of practice.

Chapter 2 – Context and literature review

The first part of this chapter offers a bibliographic overview capturing the various forms of literature, including discussion papers and articles from a variety of sources, written in relation to the research topic. The second part of the chapter focusses on a critique of previous studies and research articles. It includes discussion of their

methods and results, including any existing gaps in knowledge, together with the contribution to knowledge that this present study will provide. Current literature suggests that there is a need for further research on the content and delivery of medical ethics education (Eckles et al. 2005). Research exists on the needs of an international workforce in the medical profession (Hindmarch 2005; Rothwell et al. 2013). However, there exists a gap in knowledge with regards to the evaluation of PMSPs and how they meet the needs of medical students within the field of medical ethics. Currently, no research has explored the perspectives of Malaysian medical students on PMSPs, nor specifically how they develop an understanding of the ethical dimensions of practice.

Chapter 3 - Methodology

This is a qualitative study and has its basis in interpretive phenomenology. The nature of this study, which includes my position as the researcher, lends itself to be guided by the works of various influential philosophers within this field such as Martin Heidegger and Paul Ricouer. The chapter offers a presentation of the philosophical underpinnings which have guided the research design and its methods of data collection and explication. The chapter provides a discussion which presents the rationale for adopting the interpretive phenomenological perspective and the works which support this approach.

Chapter 4 - Methods

The design and methods used were chosen as the optimal approach to addressing the research question, aims and objectives of the study. The data collection process involved semi-structured interviews, which comprised an interview guide which allowed for freedom of expression by the participants. The interviews were transcribed verbatim, and then the data was explicated utilising a thematic analysis framework. The chapter will present these in further detail with regards to choice and size of sample; recruitment of the sample population; choice of data collection and the rationale for its use; and data interpretation, the strategy for this and its alignment with the adopted methodology.

Chapters 5 and 6 - Findings

The findings are presented in two chapters - chapters 5 and 6. Chapter 5 presents the findings regarding the means by which students developed their understanding of the ethical dimensions of practice. This includes exploration of their observed experiences across the different placement settings and how influences such as culture, beliefs and values facilitated their understanding. This chapter also offers an interpretation and discussion of the findings pertaining to the ethical dimensions of practice. Chapter 6 presents a model of the factors influencing ethical sensitivity for students on a partner medical school programme, which was developed from further analysis of the data. It offers a discussion of the model through the application of a concept analysis framework, together with its practical applications for the future.

Chapter 7 - Discussion

This chapter offers a discussion of the key findings of this study and ascertains the meeting of the aims and objectives of the research, together with identifying challenges associated with the sample population, and limitations to the study. A discussion of factors originating from the proposed model is offered in this chapter, and relates these to existing literature, thus affirming the position of this study within the wider research, and its original contribution to knowledge. This chapter also offers further discussion of the implications of this study on current education practices, and proposes future research stemming from this PhD study.

Chapter 2

Context and literature review

Introduction

This chapter reviews the literature concerning the research aim: "an exploration of how Malaysian medical students on a partner medical school programme develop an understanding of ethical dimensions of practice". The discussion focuses on the knowledge that currently exists in relation to the research topic, whilst highlighting gaps in this body of knowledge.

The sourcing of the literature and the reasoning for using the selected literature will be presented, together with the analytical tools applied for reviewing the literature. In order to set the backdrop for this study, demonstrating the degree of interest and level of discussion of the subject matter within the academic community, this chapter commences with an introduction to teaching medical ethics. It presents a collection and review of the literature available with respect to medical ethics education. The section on searching and selecting the literature provides the strategy and frameworks applied in searching and selecting the literature for review. A review of the research consists of the analysis of the studies conducted within this field, offering a critique of the literature, via contrasting and comparing the available sources, their methods, methodologies and findings, as well as identifying areas for further exploration within the topic.

Teaching medical ethics

The literature surrounding the teaching of medical ethics demonstrates that, internationally, medical ethics programmes vary between academic institutes, in terms of content, amount of time dedicated and mode of delivery (Miyasaka, 1999; Rameshkumar 2009). The literature reveals that there is research focused on the optimal methods for teaching medical ethics. Preferred learning methods by students included clinical experiences and observation of senior colleagues in the clinical area, small group discussions led by clinicians or ethics consultants and role

modelling of behaviour (Al Mahmoud et al 2017). However, lectures being a traditional format for delivery of medical ethics are still utilised in medical schools (Alkabba et al 2012). The aim of medical ethics education is debated within the literature, with some espousing that its purpose is to develop inherently virtuous clinicians, whereas the other standpoint sees the purpose of medical ethics education to provide future clinicians with the necessary skills to navigate the ethical dilemmas they will encounter in practice (Eckles et al, 2005). As Singer (2000) describes:

> *the goal of medical ethics is to improve the quality of patient care by identifying, analysing, and attempting to resolve the ethical problems that arise in the practice of clinical medicine (p. 282).*

The underpinning moral philosophy of medical ethics

Medical ethics consists of different strands of moral philosophy, which have shaped modern medical ethics. This variety of philosophies makes medical ethics complex as, at times, different theories could advocate conflicting courses of action, such as the case of adopting a utilitarian or deontological stance, with a view to resolving an ethical dilemma (Cowley 2005). In such cases, the outcome is therefore unpredictable and physician-dependent, and thus practices will vary globally in light of the predisposing philosophy that guides medical practice. Moral and ethical standards are relative to the moral standard of a person(s) or culture, as opposed to the existence of an absolute standard. Yet, there are some principles that are universally accepted in global medicine, such as beneficence (to do good) and non-maleficence (to do no harm).

Arseculeratne et al. (2016) presents the journey that medical ethics has taken from its origins in Ancient Greece and Hippocrates, and how it continues to be cited as a representation of the expectation of the conduct of a physician (Jonsen 1999). During the Nuremberg Trial for Nazi War Crimes it became apparent that the Hippocratic Oath had not been sufficient to prevent the human experiments conducted under the rule of the 3rd Reich and the Nuremberg Code was developed,

where the concept of beneficence was modified with the addition of non-maleficence; promoting the empowerment of patients, and the use of informed consent, thus promoting patient autonomy (Volpe 1998). This was followed by the Declaration of Helsinki, now in its 7th revision (WMA 2016). Aresecularatne et al. (2016) highlight that this history has resulted in the teaching of the principal of autonomy and beneficence, on a worldwide scale, in attempts to protect health service users and regulate practitioners.

Foundation of ethics teaching: Key ethical concepts

Although medical ethics is comprised of various moral principles, these key ethical principles can be generally categorised into four branches.

Consequentialist theory; or forward-looking theory, focusses on the consequences or result of an action, with the correct moral response to an act being based on its consequence. Utilitarianism is one such theory, which promotes acts that maximise utility. Guidelines are often based on utilitarian values, as having to constantly assess the consequence of each action may be time-consuming and difficult. This is a significant theory which, within medical ethics, often overrides other moral theories. Utilitarianism relates to the greater good for the greatest number. In medicine, this is often referred to as the public interest. Therefore, in a medical culture that promotes patient autonomy, the public interest would override the rights of the one individual. This is evident when a doctor's duty to uphold patient confidentiality is breached with the utilitarian view to uphold the best interests of the population.

Deontology, or duty ethics, is based on duties and rights, and respects individuals as ends in themselves. Value is placed on an individual's intentions within the act as opposed to the outcomes of any action. It focuses on rules, obligations and duties, with the expectation that individuals will always fulfill their duty. Adherence to these obligations and acting from duty is viewed as acting ethically. Under this theory, some actions are always defined as right or wrong, e.g. to maintain patient confidentiality may be deemed as always being an ethically-correct action under this principle.

Virtue ethics, as opposed to both the aforementioned theories, places an emphasis on the virtues which a person's character embodies, which determine the ethical behaviour of an individual (Carr & Steutel 1999). This includes truthfulness, honesty and trustworthiness as positive characteristics of doctors, and is aligned with professionalism and professional behaviour.

Principlism was established by Beauchamp and Childress (1974) and bases itself on the four key ethical principles of:

>Autonomy – self governance

>Beneficence – the act of doing good

>Non-malificence – above all do no harm

>Justice – fairness/equality

It attempts to combine the best elements of ethical theories which are compatible with most societal, individual or religious belief systems (NHS Scotland 2012). According to Gillon (1994):

>*It (the 4 principles) offers a common, basic moral analytical framework and a common, basic moral language. Although they do not provide ordered rules, these principles can help doctors and other health care workers to make decisions when reflecting on moral issues that arise at work*
>(Gillon 1994 p.184).

The 4 principles approach combines various ethical theories, including utilitarianism and deontology, but also combine theories of libertarianism as part of the construct of autonomy, together with theories of justice. Within healthcare systems, justice theories include entitlement theory, which concerns itself with all individuals being considered equal and a distribution (of healthcare) being just if all individuals are entitled to it (Nozick 1974, p. 151). Also included is the concept of distributive justice, which promotes that all individuals should have an equal right to the most basic liberties. It also states that in a system where social and economic inequalities exist, these should be arranged in a manner which benefits the least advantaged members within society (Rawls 1971, p. 92). Within healthcare, these theories are evident in the distribution of healthcare resources and means testing of a person's entitlement

to treatment and/or services that are not considered to be the most basic of needs. The application of these theories to ethical dilemmas can be time-consuming and relative to individuals' moral views. In the UK, professional bodies such as the GMC provide guidelines for practice based on the above theories. The aim of these guidelines is to provide consistency amongst clinicians, ensure equity and safety of service provision, and promote professionalism. The challenges that exist here are that these guidelines are produced by and for a specific society, but may not be transferable across other groups of doctors within a global society. This is not only based on moral relativism, but also on the differing definitions and expectations of professional behaviour globally.

Challenges of the 4 principles approach to healthcare ethics

The 4 principles approach (Beauchamp & Childress 1974) has long been favoured by many, and is used globally by various universities as they aim to aid healthcare professionals in their ethical decision-making (Gillon 2003; Page 2012). However, as stated by NHS Scotland (2012), these principles are based on the shared values of a specific society and thus may not be culturally relevant to all. The 4 principles approach was developed in the United States, and their relevance within some educational contexts has been questioned by Leavitt (1997), who presents the argument from a Judaic perspective in response to Yali's (1997) article on "Teaching Medical Ethics to Students in Beijing." Leavitt (1997, p.12) states:

> …*of course, medicine is an international profession and Western ideas have their place. But then so do ideas from our own cultures. Just as Jewish tradition cannot be ignored in medical ethics teaching in Israel, so I should have expected also Confucianism, the Tao, Marxism… (Leavitt 1998, p. 12).*

Leavitt (1998), challenges the relevance and appropriateness of teaching the 4 principles approach within a cultural setting that bases its ethics on Taoism, Marxism and Confucianism. Leavitt (1998) is critical of the content of the ethics programme in a Beijing university of what he describes as "highly Western" concepts such as autonomy, deontology and utilitarianism, as opposed to ethics concepts which are more relevant to China as they are based on the Tao, Marxism and Confucianism. Other authors such as Qui (2004) and Tsai (2002) present the argument that

teaching Western principles to Chinese students is an example of the hegemony that exists, as Western society imposes its values on other cultures.

Teaching medical ethics within the globalisation of medical education

With the flourishing globalisation of medical education, the education of medical ethics takes on new and pivotal debates, especially in relation to conflicts relating to developing technologies and indigenous traditional methods of healing. Authors such as Iserson et al. (2012) and Aresculeratne (2016) suggest the need for cultural sensitivity with a view to accommodate the varying perspectives that exist within cultures, which would therefore tailor the care provided to the needs of the patients, and minimise the imposition of one set of ethical values to a global healthcare population. Turner (2003) calls for the need for physicians and other healthcare workers to acknowledge the culturally diverse society that they practice in, and they challenge "conventional readings in biomedical ethics as being ill-equipped" (Turner 2003, p. 194) to assist in dealing with dilemmas within such a society. Iserson et al. (2012) highlight the need to modify Western responses to ethical and moral dilemmas and ensure cultural sensitivity. Iserson et al. (2012) suggest the importance of recognising cultural uniqueness (or being culturally sensitive) and approaching situations with an awareness of local needs and norms. Further to this, Iserson et al. (2012) consider that while adhering to some cultural norms may conflict with Western ideals, this approach would correspond to the principle of autonomy, thus respecting culture and social norms, as well as the person (2012, p. 687).

Content of ethics curricula

Miyasaka et al. (1999) and Alkabba et al. (2012) explored the content of ethics curricula, in terms of time dedicated to ethics courses and specialist qualifications of those teaching ethics.

The study of ethics curricula by Miyasaka et al. (1999) involved the conducting of a survey as a means of identifying the content of ethics curricula across 206 medical schools in Asia. Their study involved the distribution of a survey to medical schools

in China, Hong Kong, Taiwan, Korea, Mongolia, the Phillipines, Thailand, Malaysia, Singapore, Indonesia, Sri Lanka, Australia and New Zealand. The questionnaire aimed at gathering information on the specific aspects of ethics courses offered, including the length of the course, whether it was compulsory or elective, and the year(s) of study at which the course was offered to students. The second part of the questionnaire asked for the personal opinions of the Deans of the medical schools regarding the importance of ethics education, the degree of satisfaction with these courses, and their preferred background of those teaching medical ethics to the students.

The main findings from Miyasaka et al. (1999) showed that from a response rate of 49% (100 respondents from 206 questionnaires distributed), medical ethics had become a universal component of medical school curricula across schools within Asia. The authors indicated that the countries whose medical schools demonstrated a difference to others were China, where there was a significant number of non-respondents which could therefore significantly impair the results, and Japan, where it was felt that cultural and language issues, in terms of translation, may have affected how the subject of medical ethics was identified. However, Miyasaka et al. (1999) state that many medical ethics programmes have been developed with an Anglo-American social context in mind. This could therefore affect the engagement of countries such as Japan and China with such programmes due to the relevance and transferability of principles to their cultural needs, as raised by Leavitt (1997) in his critique of Yali's paper (1997). Although Miyasaka et al. (1999) focused on issues of curriculum, there are undertones of cultural influences within their findings. A feature in this study is the use of the word "Asia" in the title, whilst including countries such as Australia and New Zealand within their sample. From a geographical perspective these countries form the continent of Australasia, and their social contexts have a basis in what are considered Western perspectives. However, in light of the age of this study by Miysaka (1999), a review of the content of ethics curricula across medical schools is recommended. This will reflect changes within medical curricula in these medical schools and changes in the opinions of the Deans to reflect the current status.

Alkabba et al. (2013) solely focused their study on the ethics curriculum of universities in Saudi Arabia and concluded that at the time the teaching of medical ethics was in its initial stages. However, they further added that the main challenges faced by teachers of medical ethics was a lack of guidance on achieving uniformity across a curriculum that addresses religious, professional and practical aspects from Western and other non-Islamic sources, with a view to preparing graduates for practice in non-Islamic countries or when caring for non-Muslim patients (Alkabba et al. 2012). Thus, although their main focus was on curriculum content, Alkabba et al. (2012) demonstrated the need for culturally-sensitive ethics. In addition to this, the authors also explored how ethical knowledge and understanding was assessed, with a final examination being the preferred method over objective structured clinical examinations (OSCEs) and objective structured practical examinations (OSPEs).

Global, universal and culturally sensitive medical ethics

The changing face of education, the use of technology, consideration for different learning styles and the burgeoning context of the globalisation of medical education programmes has challenged the style of delivery of ethics teaching and questioned the efficacy of it in enabling medical students to become ethically-competent practitioners. The conceptualisation of "ethically competent practitioner" and having "sound ethical understanding" is one of the building blocks of professionalism (Mueller 2015), and is recognised as a complex social construct, where situational context, geographical context and culture are important considerations (Jha et al. 2015). There is no consensus on the definition of professionalism or the best methods of teaching it on medical programmes. Martimianakis et al. (2009) propose that professionalism is multidimensional and more complex than simply being a "list of behaviours and attitudes but is a value-laden term with societal, institutional, historical and contextual expectations built into it" (Martimianakis 2009, p. 830). This presents the complex nature of achieving a global sense of professionalism, and the challenge this poses for both students and doctors alike when attempting to understand expectations of the profession when working internationally. Hodges et al. (2010, p. 17) conclude that a consensus of the definition of professionalism is difficult to achieve given the diversity of how the phenomenon is understood.

In their systematic review of best evidence in teaching professionalism in medical education, Birden et al. (2013) argue that teaching professionalism is different from teaching technical clinical skills, highlighting Huddle's (2005) point that when successfully taught, it impacts on and shapes the person's moral identity. Defining professionalism as an ethos aligned with humanism, Birden et al. (2013) conceptualise professionalism as incorporating patient empathy, work-life balance and integrity.

Weber (2004) discussed multiculturalism and professional practice, and the daily challenges that practitioners face due to cultural diversity through working in a multicultural society, but did not specify if these challenges are limited to a particular country or continent. Supporting UNESCO's (2005) view, many theorists, including Drane (2016), argue that there exists a universal approach to medical ethics, evident in a global unified approach. However, Chattopadhyay and De Vries (2008) criticise the universal approach, and propose that a universal declaration could be perceived as contradictory to the cultural norms and moral values of a major part of the world, as this approach results in "questioning the foundations of several Eastern religions and spiritual traditions" (Chattopadhyay & De Vries 2008, p. 3).

Due to the global nature of medicine, and the international movement of medical practitioners, Aresculeratne et al (2016) argue for the necessity of a global agreement as to how patients should be treated, with a view to achieving a consensus on accepted practices worldwide. However, Rameshkumar (2009) questions the existence of a universal method of teaching medical ethics with global applications. Their paper comments on the needs of non-Western developing countries in relation to medical ethics, "as the culture, religion and practices are diverse and the content of the curriculum should be sensitive to this" (Rameshkumar 2009, p. 338). Rodriguez Del Pozo & Fins (2005) suggested that the autonomy-based ethics that are so prevalent in Western medicine would be alien or discordant to the traditions of the Qatar students' religious and professional values. Yet, autonomy is not the sole concept on which Western medical ethics is based. Nor (2001) noted that in both Western and Islamic medical ethics there exists a common deontological dimension which holds "chief place" across both philosophies. This is

to say, that there must be a denomination of the rightness or wrongness of the action and not only the good to be gained from medical care or research (Nor 2001).

Yali (1997) rejects the 4 principles approach as a means for teaching medical students within Asian universities. Yali (1997) alludes to the hegemony of Western medicine by suggesting that the application of Western ethics to medical curricula in Asia is simply a demonstration of the West's perception of their own superiority, and thus the imposition of their values. This was evident during the British rule of Malaysia whereby traditional medicinal practices were tolerated yet considered inferior due to their emphasis on religion and superstition over science (Ooi 1991; Falconer 2015). Weber (2016) claims that the professional medicine of Western cultures has become the dominant force of medical intervention. In the post-colonial era, the World Health Organisation conducted a report on Malaysia, which led to the expansion of Western-style medical care (Ooi 1991). It is the scientific nature of the approach that overpowers traditional methods of medicine and thus what is being opposed by authors such as Leavitt (1997). However, Rodriguez Del Pozo and Fins (2005) quote Pellegrino (1992), who called for the putting aside of cultural differences when searching for universal ethics:

> *The ethics of medicine offers a fruitful point for beginning a larger cultural dialogue between and among the world's major cultures… As the transcultural dialogue in medical ethics continues, it should serve as an encouraging prototype for the larger dialogue between and among all ethical systems… Let us hope the dialogue continues and that medical ethics will serve to re-emphasise our shared fate as humans (Pellegrino 1992 in Rodriguez Del Pozo & Fins 2005, p. 2).*

It is Pellegrino's (1992) phrase "shared fate as humans" that promotes a universal approach by focussing on the similarities shared between cultures. Nor (2001) concurred with this view by focussing on the similarities, pertaining to deontology and the rightness and wrongness of an action, between Islamic and Western medical ethics. However, Nor's (2001) paper emphasises a move away from patient-centred ethics to a God-centred approach;

> …a code of medical ethics thus formulated in awareness that there is a Divine God who supervises all things, would mean that it is likely to engender humility in doctors and hence have a more ethical approach (Nor 2001, p. 53).

Therefore, it may be this lack of agreement amongst academics that could be one of the contributory factors to the expanse of discussions on medical ethics that continue to revolve around the central arguments of curriculum and global applications. There are authors, however, who call for a basic cultural awareness and sensitivity within the UK when caring for patients such as those of the Islamic faith, with a view to providing the best care for these patients (Gatrad & Sheikh 2000).

Philosophy and religion

The role of religion holds a key position within the development of ethical principles. The rise of Christianity was one of the major influences on the development of Western philosophy, whilst Asian philosophies are influenced by Hinduism, Buddhism and Taoism and can be differentiated between South and East Asian. Although Tsai (2002) spoke of the hegemony of Western principles through their imposition onto Asian cultures, there also exists a degree of commonality between Western and Eastern religions. Thus, discussions of a universal approach being contradictory to existing cultural norms may be challenged through the shared similarities of world religions.

Christianity emphasises that man's duty to God was more important than his duty to the state. In addition, Christianity preaches about forgiveness, love thy neighbour, doing no harm and truth-telling, amongst others, which are shared with Eastern religions (Caron 2017; Slane-Oppelt 2012). There are general aspects of life that Indian philosophers agree on, and one of these relates to the art of self-discipline, which can be achieved when it is channeled through activities of "worship and devotion, the activities of work and the activities of knowledge and concentration" (Koller 2007, p. xvi). There is also agreement, based on the Hindu perspectives,

about the importance of living morally and fulfilling one's moral duties, especially the duty to avoid hurting other living things (Koller 2007).

East Asian medical ethics is underpinned by Eastern philosophers such as Confucius, and thus has adopted a paternalistic approach to the healthcare system (Fuscaldo et al. 2010). Confucian theory views beneficence as the favourable approach but does however in turn diminish "the respect for individual rights and autonomy" (Tsai 2002). This is in contrast to the principle of respect for autonomy that is stressed within Western medical ethics (Tsai 2002), yet both approaches emphasise beneficence (to do no harm), which is the central principle advocated in medical ethics.

Nor (2001) criticised the use of the Hippocratic Oath in countries such as Malaysia. As a Muslim, Nor (2001) revoked the Oath as she felt that it was based on a multi-God faith, and thus not reflective of Islamic medical ethics. Yet, Jonsen (1999) argues the Oath continues to be cited and referred to when discussing actions and conduct of doctors.

Language barriers and cross-cultural ethics

Ypinazar and Margolies (2004) conducted a qualitative single-stage study with 62 Arab students in a university in Qatar. The study investigated how Arab medical students, whose first 4 was not English, understood and identified Western ethics, in the form of the four principles, in ethical dilemmas within the clinical setting. They demonstrated that the students could identify the 4 principles within an ethical dilemma encountered in the clinical setting. The 4 principles of healthcare are often utilised as a framework with which to address ethical dilemmas, whereby if all 4 principles are considered with respect to a particular ethical dilemma, it will lead to acting in the best interests of the patient. Ypinazar and Margolies (2004) share similarities to Fuscaldo et al. (2010), who also explored the students' relationship with the 4 principles and their ability to apply them to clinical practice in Malaysia. Both studies involved written data collection but differed in their approach. Fuscaldo et al. (2010), utilised a questionnaire with semi-structured questions to enable their participants to provide long answers to their questions, as opposed to single word

answers. Ypinazar and Margolies (2004) assessed essays written by the students, in which they reflected upon experiences in the clinical setting, and the ethical dilemmas they identified based on the 4 principles framework.

Ypinizar and Margolies (2004) clearly identified the nationality of their student participants as their study was based on the nationality and cultural/religious identity of the student participants and how this impacted on their ability to identify the 4 principles within a clinical situation. In contrast Fuscaldo et al. (2010) do not refer to this aspect of their sample population. Providing this information would have provided context to the results, enabling the reader to better understand the results from the participants' perspective. The 1997 study by Yali, conducted in a Beijing University, does not state whether the students interviewed were Chinese, or of other nationalities.

Ypinazar and Margolies (2004) utilised students from two cohorts from the academic years 2002-03 and 2003-04 and ensured that the students attended the same GP surgery on their clinical placements, at the same time in the academic year and that the reflective pieces were written within the same timeframe. They concluded that these students were able to correctly identify the 4 principles of healthcare in ethical dilemmas after being taught this is in English, which was not their first language. It has been previously discussed that other studies e.g. Fuscaldo et al. (2010) and Yali (1997), do not provide details about the nationality or other particulars about their sample population apart from the year of study and ratio of male to female students. Yet, Ypinazar and Margolies (2004) do provide details in terms of nationality, and thus provide the reader with a clear picture of who the students are, thus adding context to the results. Ypinazar and Margolies (2004) concluded that the students were able to identify ethical dilemmas using the 4 principles framework and noted the fact that they felt that this might have been a challenge for these students, as Islamic medical ethics is based on a deontological approach, and thus differs to the 4 principles which they were being taught.

Culture and conflict between theory and practice

Studies relating to ethics curriculum, content and teaching, e.g. Alkabba et al. (2013), often discuss the need for cultural sensitivity within medical teaching and clinical practice, in a move towards a global approach to medicine. Fuscaldo, Russell and Delaney were based at Monash University in Australia and it was within their roles in undergraduate medicine, working with the medical students, that their interest in how medical students perceived the suitability of the 4 principles approach across different cultures arose. The essence of the study by the Fuscaldo et al (2010) above, entitled "Enhancing Cross Cultural Understandings of Ethical Issues in Medical Education," was a qualitative investigation of the impact of teaching Western medical ethics (4 principles approach) on the students' ability to address ethical dilemmas in the workplace, whilst on clinical placement in a hospital in Malaysia. Although the students in Fuscaldo et al's (2010) study conducted their clinical placements in Malaysia, they were still part of Monash University and not a different higher education institution or part of a partner medical school programme

Fuscaldo et al. (2010) found that students on their corresponding clinical placements face cultural conflicts in ethical approaches, especially when they are taught a set of principles that do not meet the cultural needs of the country they are placed in, and thus they call for a cultural sensitivity in the delivery of medical ethics teaching. This has been a topic that has been discussed at length by Iserson et al. (2012), Asceluratne et al (2016), Tsai (2002) Yali (1997) and Leavitt (1998). A study by Elit et al. (2011) shared some similarities with Fuscaldo et al. (2010) with regards to the challenges faced by students in dealing with ethical dilemmas when on placements in a different country. Other authors, e.g.Turner (2003) and Iserson et al. (2012), call for culturally-sensitive ethics in contrast to a universal approach to medical ethics. However, in their research, Elit et al. (2011) presented the challenges experienced by medical students from a Canadian university on international health electives (IHE) in Africa, Asia and South America. The challenges consisted of conflicts which arose from the students' interactions when working within local services whilst on their global health electives with regards to being asked to work beyond their competency level or observing behaviours that made them uncomfortable, such as a lack of privacy and confidentiality for patients. The authors therefore call for pre-

departure training for students to include their expectations of the placement and learn about local context. Although Elit et al. (2011) do not make reference to the term culture, the issue of culture itself is implicit when they speak about local context. This work arguably highlights that experiential learning has a place within ethics education, especially with regards to "professional knowledge acquisition; critical thinking and clinical problem solving and lifelong professional learning" (Maudsley & Strivens 2000:535). This is further discussed below.

Evaluating teaching methods – how best to teach medical ethics

Learning styles, differences in language and attitudes from other students and teachers are considered barriers to general teaching and learning for international students (Hudson & Todd 2000; Carroll & Ryan 2005). However, international students can often have issues relating to family or finances that can impact on how they integrate and engage with a course (Hudson & Todd 2000). How learning takes place can be influenced by a student's culture and, although students may have personal expectations, they may also bring with them cultural expectations of learning (Carozzi & Jin 1997). Such influences include the perception of the student-teacher relationship and the interactions that a student should have with their teacher. According to Welikala and Watkins (2008), some students have expressed that teachers are the ones who talk within the classroom setting and should not be interrupted, as this would have a negative impact on learning. However, Welikala and Watkins' (2008) work is on "the improvement of intercultural learning experiences in higher education", but they do not provide a definition of what is meant by an "international" student. Their study was conducted with 40 international students within a UK university originating from Europe, African, Asia, the USA and Canada. According to these authors, the cultural norms for these students are based on the assumption that the teacher is the focal point of the lesson and should be respected and unchallenged. Therefore, a learning environment where the teacher is addressed by their first name, and where the questioning of ideas is welcomed, can prove challenging for international students.

Stirrat (2014) reflects on the teaching of ethics in UK medical schools and how this has developed over the past 40 years. In his paper, Stirrat (2014) proposes the need

for continuous development of the ethics curriculum and reduced complacency with a view to upholding standards of care. The perspective of those learning about medical ethics is researched and discussed within papers and journal articles, e.g. Dennis & Hall (1977). Research has shown that the key aspects impacting on how students learn about medical ethics are their understanding of concepts, application of concepts being taught within a culturally diverse environment, and evaluation of teaching methods for medical ethics.

One extant research study from 1997 was published in the Journal of Asian and International Bioethics. The study investigated "The Teaching of Medical Ethics in Beijing Medical University" (Yali 1997). It involved surveying 107 medical students prior to and following an ethics course, which included the history of medical ethics, the study of ethical theories including deontology, utilitarianism and virtue ethics, and the 4 principles approach. The purpose of Yali's (1997) study was to evaluate the efficacy of the reforms to the course programme, and how these reforms impacted the students' perception of the educational model used for ethics teaching. The results of the pre- and post-course survey showed a marked improvement from an initial 39% of students not being interested in ethics (pre-course), to 11% of students not being interested (post course). According to Yali (1997), the pre-course results were affected due to the content of the course as only some principles, theories and standards of general and medical ethics were taught (Yali 1997). The post-course results were based on the reforms in the teaching programme whereby there had been a systematic approach to the delivery of ethics including a history of medical ethics, principalism and ethical theories. Other reforms included utilising case-based discussions, which was different to the previous modes of delivery of the subject.

Case-based discussions are viewed favourably by students, but their engagement is further enhanced when they are able to discuss their own experiences in contrast to using standardised cases (Vertrees et al 2013). Such methods have been in use for some years within the medical profession through the use of clinical debrief and Balint groups (Mahoney et al 2013). Other surveys indicate that students are keen for experiential learning to be developed as part of their medical education programmes (Mattick and Bligh 2006) and not specifically the partner medical school programme.

Alkabba et al. (2012) evaluated their ethics teaching programmes in Saudi Arabia, using quantifiable data from examinations and other assessments. The data was produced from a sample population of academics and, thus, failed to capture the perspective of the students. Although their research methods produced conclusive results on the efficacy of their teaching programmes and demonstrated the students' knowledge of medical ethics within academic settings, they did not demonstrate the students' understanding of the application of medical ethics in the clinical setting. The authors had clarified that the purpose of the medical ethics programmes was to prepare students to care for patients of non-Muslim backgrounds. This demonstrated the insight of the authors into the requirements of doctors working within a global medical community. However, the data collection methods in the evaluation of the programme did not gather the perceptions of the students regarding their understanding of what is expected from them as professionals when working overseas and what challenges they envisaged.

Miyasaka et al. (1999) evaluated teaching programmes from the perspective of the Deans from 100 medical schools. The findings of this study highlight the issue of moral relativism, though it is not classified as such within the results. The authors identified that there existed differences between countries in the responses to some questions. An example of this was with regards to the issue of population control, which was highly evaluated in China, indicating that the Deans of these medical schools felt that this was a topic that required inclusion within their ethics curricula. In addition, Miyasaka et al (1999) speak of ethics programmes being based on Anglo-American perspectives. Thus, the criteria for selection in the questionnaire are based on ethical considerations that may not be common amongst certain cultures but have been previously considered to be aligned with Western principles, although the authors suggest that Asian countries are more secular. This study focused on medical ethics curricula in Asia, yet includes universities in Australia and New Zealand. Although from a geographical perspective these countries are considered Asian, their cultural setting is more conducive to what is considered to be a Western lifestyle.

The role of experiential learning in medical ethics education

Logar et al. (2015) suggest that one of the most effective ways to learn ethics in the context of global health is through working within the service. Adult learning theory proposes that adults prefer to be in control of their learning and are especially receptive when they can see the practical applications of their learning (Kolb 1984). According to Kolb (1984) experiential learning occurs in a cycle which includes the following steps: 1) Having the experience – 2) reflecting on the experience – 3) learning/making sense of the experience - 4) actively implementing the learning.

Reflection is a key component within lifelong learning and utilised within the medical profession through the maintaining of professional portfolios. According to Elango et al (2005:511) the maintaining of a professional portfolio, "is deeply rooted in experiential learning." Branch (2005) expresses the need for medical schools to invest in providing sufficient resources for reflective learning and creating a safe and comfortable environment in which this can occur, led by a skilled professional (Branch 2005: 1065). In addition, Mattick and Bligh (2006), suggest that one of the key components in experiential learning is having appropriate supervision and support in order to enable students to deal with ethical dilemmas, and would therefore aid in the students' reflection and making sense of the experience. This is further supported by the work of Aukes et al. (2008), who found that having supported reflection on experiences (enhanced experiential learning) had a positive impact on the reflective abilities of medical students.

Whilst international health electives provide students with a range of experiences and exposure to ethical dilemmas, the issue that arises is that within the host countries and their placements, there is often a lack of supervision and resources to facilitate support and reflection on their experience, thus jeopardizing the learning experience (Tubman et al. 2017). Furthermore, it is argued that clinicians in low economic resource settings are often in great demand.Therefore, supervising a visiting student could deter their attention and impact patient care (Elansary et al 2011). Even within UK universities there is a call to make experiential learning more systematic as opposed to it being incidental and opportunistic (Mattick and Bligh 2006). The use of personal cases in teaching medical ethics based on students' own

experiences (as opposed to standardised cases) enables students to engage better with the learning, according to Vertrees et al. (2013).

Earlier in this chapter (page 17) observation and role modelling was discussed as a preferred method for learning about ethics by medical students. However, although experiential learning is preferred, students can observe different practices of varying quality. In addition, authors such as Goldie (2000) and Grace et al. (2016) recognise the benefits of experiential learning within medical ethics, yet there is still a call for supervision and the need for theoretical input with a view to inculcating in "students and (medical) residents the knowledge, values, attitudes, and behaviours that characterise medical professionalism" (Swick et al 1999:832). This suggests that theoretical ethical knowledge and adequate supervision to reflect on events is required to support the development of appropriate skills and behaviour. It is noteworthy that the General Medical Council (GMC) indicates that experiential learning is the most important educational element in developing knowledge, critical thinking and clinical problem-solving (Maudsley and Strivens 2000).

In regard to the theoretical aspect of medical ethics education, Ashcroft et al. (1998) recommend a mixture of lectures and small group work, whereas Maudsley & Strivens (2000) agree with a variety of approaches. In their evaluation of programmes, students have cited their preference to work in small groups where there is opportunity to discuss cases (Glick 1994), as well as learning through discussion with experts within medicine, e.g. consultants (Roff et al. 2003). However, according to Sofaer (1995) it is recommended that tutors facilitating the group work have an awareness of the main ethical issues that medical students experience on their clinical placements. Further to this, Sofaer (1995) sees roleplay as an integral part of ethical teaching as it develops the experience of students in addressing emotions and uncertainty of the cases being played out.

Steinberg (1998) recommends a multidisciplinary approach to teaching medical ethics which aims to "integrate the teaching of medical ethics into all fields of medical practice and not [be] confined to theoretical lectures squeezed into the busy schedule of medical students" (Steinberg 1998:12). Steinberg (1998), does not however specify which country or university this claim would apply to - either Eastern

or Western countries. Sabin (2009) describes ethics as being well established in Western countries, thus implying that ethics forms a part of everyday clinical education and practice. However, Sabin's work was published much later than the suggestions published by Steinberg (1998), but still Sabin (2009) describes how some non-Western countries, at that point in time, were not offering a dedicated medical ethics programmes.

> *Medical ethics is not well developed as an academic field in India. To the best of my knowledge there are not medical school departments of ethics. Minimal curricular hours are dedicated to this subject (Sabin 2009:1).*

Roff & Preece (2004) reported that medical students showed a preference to be taught medical ethics by clinicians, as the students felt that it enhanced their learning experience. Behrens and Filligan (2013) took these notions of the qualities of ethics teachers further and suggested the need for these teachers to be role models and practice the principles they advocate in their teaching. Therefore, there are a number of issues relating to the content of the curriculum, what structure a session should have, and even the professional and personal attributes of those delivering the content.

What is known of the medical students' views about their understanding of ethical issues in clinical placements

The previous discussion has highlighted that clinical placements in different countries during medical education are widely offered across the globe. There has been evaluation of teaching methods, curricula content and exploration of the views of academics, yet optimal teaching methods remain a subject of professional debate. This literature is largely teacher and service focused, which raises the question about what is known about the student experience. To explore whether a body of knowledge exists about the experience of medical students undertaking clinical placements in more than one country during their medical education, and how this affects the students understanding of medical ethics, a literature search was undertaken.

Searching and selecting the literature

Search strategy

The process of searching and locating items to be reviewed required an initial process of engaging with library databases to develop understanding of search terms and author key words that related to the research aims and objectives for the purposes of this research. Searching also involved non-electronic methods to ensure that relevant literature was located. This involved hand searching of reference lists that authors used and of journals that frequently included articles relating to the research aims.

Searches were carried out on the following databases:

Medline

CINAHL

Cochrane reviews

PubMed

ERIC

The search strategy retrieved items in English language and within the 2009-2019 period. The search terms were "medical students" AND "medical ethics" AND "culture" NOT "nursing" OR "pharmacy".

The results from this search strategy were 240 retrieved items (see table 2).

Table 2 showing the results of the search strategy

Database	Number of retrieved items
Medline	207
CINAHL	10
Cochrane reviews	1
PubMed	20
ERIC	2

Total	240

All of the retrieved items were screened by title and abstract. Duplicate and irrelevant items (such as research concerning communicating bad news in Thai culture) were deleted.

Hand searching

The second stage of the literature search involved hand searching, which included searching for articles that included the search terms described above. The following journals where searched as it had been observed that relevant items had been published:

Table 3 showing the results of the hand search

Journal Title	Number of Items Retrieved
Journal of Medical Ethics	15
BMC Medical Education	1
Medical Teacher	6
American Journal of Bioethics (AJOB) Primary Research	1
Total	23

The Journal of Medical Ethics is published by the Institute of Medical Ethics (IME) and is well known for its specialism in medical ethics. The journal publishes a variety of papers including research, systematic reviews and discussion papers amongst

others. The IME is at the forefront of improving ethics education. Medical Teacher and BMC Medical Education are both peer-reviewed journals aimed at educators who provide teaching for health professionals at undergraduate and postgraduate levels, and as part of continuous professional development, and thus their content would be of relevance as references for research involving medical students. Meanwhile, the American Journal of Bioethics, whilst also being peer reviewed, focuses on all aspects of bioethics including research and clinical ethics.

The search of these journals led the identification of 23 items (see above). The reference lists of the following authors were also searched as the researchers had completed medical education studies in Malaysia or on global health elective placements:

Table 4 showing the results retrieved through references

Author	Items retrieved through references
Elit, L. et al (2011)	3
Fuscaldo, G; Russell, S and Delany, C. (2010)	6
Total	9

Following screening of titles and abstracts from both electronic and hand searches for research concerning medical ethics education of students undertaking clinical placements in different countries, in particular partner programmes, a total of 47 items were selected for retrieval of the full article. A further process of screening and selection was completed.

Applying the SPIDER tool

Tools such Sample Phenomenon of Interest Design Evaluation Research type (SPIDER) exist to select literature and review the outcomes. The SPIDER tool was applied here as reviews by authors such as Methley et al. (2014) and Cooke et al. (2015) found that SPIDER generated more relevant results to the research question.

SPIDER assisted in breaking down the search within the various aspects of the research question. By taking these aspects into account the literature search was refined to what was specifically relevant to the research question, thus proving more efficient. Reviewing and considering previous relevant work in this area and identifying the gaps in the literature also gives rise to further questions not answered by previous work. In turn, this enabled the formulation of a more refined research question (Polgar and Thomas 2008). The table below (table 2) presents the SPIDER tool and its application to the research question of this study.

Table 5 showing the application of the SPIDER tool to the research question

S	Sample	Malaysian medical students on a partner medical school program
PI	Phenomenon of Interest	The developing of their understanding of the ethical dimensions of practice
D	Design	Interviews, semi-structured interviews, focus groups, questionnaires, surveys and case studies
E	Evaluation	Observations, perceptions, feelings, understanding, beliefs, attitudes
R	Research Type	Qualitative, mixed methods

This tool was particularly useful in streamlining the copious amount of literature that exists. It allowed management of the data by guiding the inclusion criteria and the categorisation of the material sourced.

Search results

Reading the articles and using the grid on page 38 (Table 6), enabled the researcher to assess the relevance of the literature, in relation to this study, together with aiding the process of categorisation. Thus, not all of the literature was utilised and inclusion criteria were based on relevance and usefulness to the research question. Some sources were considered as background information that framed the research and would provide context for this study. This included articles and books and provided information pertaining to the teaching of international students, medical ethics, medical ethics teaching, bioethics and global curricula. Figure 2 below provides a diagrammatic summary of the search process. It shows how the 272 articles included in the original search were refined to the 5 items of research selected for review.

Figure 2 flow diagram showing the search strategy and Results
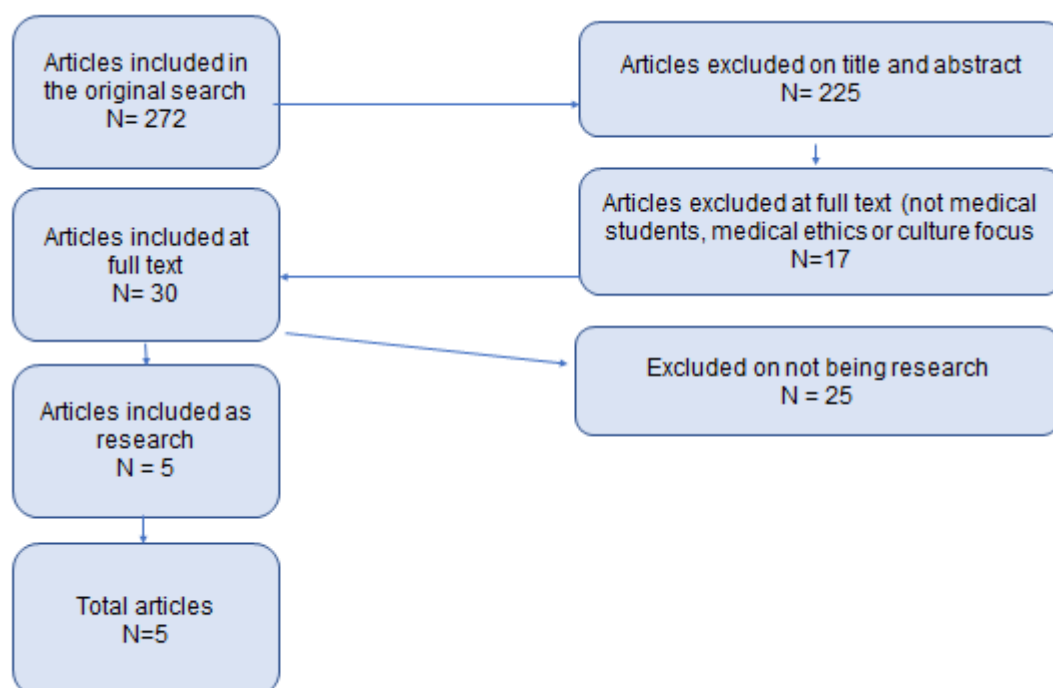
The first stage of selecting relevant articles from those identified in the original search involved excluding titles which did not include medical students, medical ethics or culture and reduced them from 272 to 225. The second step in this process included reviewing the full text and excluding those that did not focus on medical students who were completing programmes that included practice placements in different countries, medical ethics or culture or which focused on the efficacy of an existing framework, and this reduced the selected literature to 30 articles. The final part of the process excluded articles that were not research studies, such as discussion and opinion papers, editorials and systematic reviews. The 5 articles that were selected for the review were research studies that focused on medical ethics, medical students and included cultural or educational elements.

The aim of reviewing the literature was to analyse, interpret and synthesise the information collected from the search. To facilitate this analysis of the literature, a grid system was developed from the work of Henning (2011), Greenhalgh (2006) and Aveyard (2010), which compared themes, controversies and conclusions amongst authors.

The example below (Table 6) shows the grid including explanations of the details included in the analysis conducted under each heading. The grid structure provided an analytical summary for ease of reference whilst offering a clear overview of the literature reviewed and provides some examples of the articles identified in the literature search. The full selection of articles can be found in appendix D.

Table 6– grid utilised for analytical summary of the literature within the thesis (adapted from Henning 2011; Greenhalgh 2006; Aveyard 2010)

Source/ Year	Author	Title	Type of research	Sample	Methods	Results	Comments
Age of the research	Background of the author (s)	Does the title/question accurately describe the position?	Quantitative or Qualitative	How was the sample selected?	Is there enough detail provided for data collection and analysis	Credible?	Main points highlighted
Primary or Secondary source	Their perspective within the research	Is the question clearly formulated?	Was the approach appropriate?	Was it an appropriate sample?	Was there quality control?	Are the conclusions justified?	Relevance to "my" research
Reliability of the source				Recruitment methods		Transferability of results	

A review of the literature

The grid above formed part of a framework that aided the organizing of the literature reviewed. The two overarching themes that connected the literature reviewed were medical education, including student and staff perceptions on medical ethics teaching and evaluation of ethics programmes, and cultural/global issues.

Students' perceptions of professionalism in medical ethics teaching

Haque et al. (2013) explored the awareness of personal virtues in becoming a medical professional of 332 medical students in the 4th year of a medical degree, at three different colleges in Bangladesh. The study utilised a mixed methods approach, incorporating both quantitative and qualitative methodologies. The study was designed as a survey focusing on the nine core elements of professionalism, which were accompanied by various statements. In relation to each statement, the student participants were asked to rate the value of each of the core elements on a Likert scale from 1-5. This was followed by four open questions which allowed the students to elaborate on their perceptions of the core elements of professionalism. Haque et al. (2013) concluded that 83% of the students surveyed, reinforced by the responses from the open-ended questions, were unaware of professionalism, including role models. Such aspects, professionalism and role modelling, consist of qualities which are considered to be inherent factors of being a doctor as specified by professional bodies such as the General Medical Council (GMC 2009). Role modelling has traditionally been the key method through which medical students acquire qualities and develop the skill of being a professional (Byszeweski et al 2012). These qualities include patience, compassion and honesty, amongst others, are referred to as virtues and addressed under the term of virtue ethics. Haque et al (2013) concluded that a large majority of students were unaware of professionalism and the importance of role models, and attributed this to the lack of focus on the topic within the medical curriculum.

The study included 332 students and thus provided a cross section of the student body across three colleges in Bangladesh. The authors provided details of the students' gender and year of study. However, as in other studies e.g. Yali (1997) and Fuscaldo et al (2010), details of the students' demographics, in terms of nationality, cultural and religious background, were not provided. This information would have been key in understanding the findings and offer a possible insight into the high (83%) incidence of 4th-year medical students,who were unaware of professionalism. As stated previously, professionalism is attributed to virtue ethics, with Nor (2001) presenting the influence of religion on medical ethics. However, as Nor (2001) and Ypinazar and Margolies (2004) state, Islamic medical ethics are based on duty or deontological approaches. Haque et al. (2013) attributed the students' lack of awareness of professionalism to the lack of focus on this topic within the curriculum. However, it would be useful to understand the students' background in order to establish if their religious or cultural perspectives influenced their perceptions.

Although published in the English language, Haque et al. (2013) do not provide information with regards to the language in which the study was conducted i.e. English or Bangladeshi. The relevance of this is that in medical ethics language is a key factor, and concepts do not translate accurately or, in some cases, exist. For example, the term "end of life" is commonly used in Western culture, yet other cultures, e.g. some Asian cultures, do not view death as an end to life, but the transition into another life (Chaddopadyay & De Vies 2005). Thus, by the same token, if the study was conducted in English with a sample population whose first language is not English, then this could have been a contributory factor to the participants' understanding of the questions and may have influenced the responses provided. The study included four open questions with regards to students' perceptions of professionalism. Out of 332 respondents, between 270-280 did not provide a response to these questions. The authors do not offer an explanation as to why the responses were low or as to the reasons for the responses given. The use of interviews in this context would have allowed for exploration of the meaning of professionalism to these students. Professionalism is strongly associated with virtue ethics and in this study the features of professionalism included confidentiality, honesty and compassion, which are features within medical ethics teaching and the ethical dimensions of practice. According to Alkabba et al. (2013) professionalism

and ethics are taught concurrently, thus establishing the relationship between the two. In addition, this paper explored the students' perceptions on professionalism and hence why this article was selected for review.

In addition, Haque et al. (2013) do not comment on the cultural background of the student population, nor do they comment on the cultural or religious influences of Bangladesh, which other authors such as Ypinazar & Margolies (2004) do. Furthermore, Haque et al. (2013), draw comparisons with the USA and the UK when stating the importance of teaching professionalism to medical students on the basis of the increased litigation of medical practitioners. The authors do not elaborate as to why the comparison is drawn to these countries and raises the question as to how these countries are perceived by the authors.

The methods applied in Haque et al.'s (2012) study allow for the collection of larger amounts of data, from a larger sample, within a given time. Methods such as Likert scales are particularly useful when investigating a very specific question. Haque et al. (2013) utilised this method when assessing how medical students rated professional values on a scale from 1-5. This study utilised a mixed approach and included open-ended questions, allowing for participants to elaborate on the responses from the questionnaires/survey, thus adding context and detail to the data produced. This mixed methods approach offers the benefits of both quantitative and qualitative methodologies. However, written questionnaires may prevent researchers from probing and asking for clarification and elaboration on the responses. Therefore, much context can be lost with this method, thus highlighting the benefit of interviews.

Cultural and global issues

Fuscaldo et al. (2010) assess the effectiveness of the 4 principles approach in medical curricula. The study involved a semi-structured questionnaire of 40 medical students at Monash University, whilst on clinical placement in Malaysia. This study focused on the impressions of the medical students of the universality of the 4

principles. The study aimed to capture students' perceptions on future improvements to the medical curriculum, with a view to enhancing cross-cultural understandings of issues in medical ethics education. It posed the arguments to support the use of the 4 principles approach across cultures, stating that it allows for cultural relativism. It further adds that the 4 principles are as universal as Confucianism and Daoism, thus proposing that there exists a degree of commonality between philosophies.

This study did not discuss the demographics of the sample population. The authors clarified that the students were from Monash University in Australia and undertaking clinical years in Malaysia, whilst still continuing to follow Monash University's curriculum. However, it would be naïve to assume that the sample population consisted solely of students of Australian origin or from a secular society. This additional information could have brought context to the results and thus indicated if these were relative to the cultural or moral background of the students. Furthermore, knowledge of the students' background could also indicate factors such as language barriers, which have already been established as having a role in the understanding of ethical concepts. In addition, although this study has elements of a partner medical school programme, it is not considered as such because although the clinical placements are overseas the students are still attending the same medical school.

Language barriers were the subject of the study by Ypinazar and Margolies (2004). These authors explored whether students learning medical ethics in their second language could engage with what they defined as Western medical ethics, in the form of the 4 principles. The authors concluded that engagement with the ethical principles could overcome language barriers due to the shared commonalities of the 4 principles and the students' own moral values. This study was clear on the cultural background of the sample population, as this was a key aspect to their study.

However, this study was also conducted through an evaluation of essays written by the students. The authors did not engage with students and thus were not able to explore the students' perceptions of the 4 principles or their engagement with them. Further to this, the research does not discuss the students' perceptions of the practical applications of the 4 principles on their future practice.

Global health electives

Elit et al. (2011) conducted a qualitative study which focused on students on elective placements overseas. Although the sample population had undertaken a placement abroad, unlike the Fuscaldo et al.'s (2010) study these students were away from their home university on a short placement. Elit et al.'s (2011) study aimed to assess the main challenges that students from wealthy countries encountered when on an international health elective placement in a developing country. Elit et al. (2011) identified five issues in their findings which included uncertainty on how to help; the notion of being different as a Western medical student; working beyond their scope of practice; navigating different cultures of medicine; and unilateral capacity building (2011:704). Further to this, the authors aimed to find ways in which to better support these students and concluded that pre-departure training would have better prepared the students on their international health elective, together with having a supervisor whilst on elective, having contact with their home institution and a formal debrief upon their return (Elit et al 2011:704).

The sample population were from four universities in Canada, and Elit et al. (2011) did not provide information on the stage of training which the students were at when they went on their elective placements, but stated that would have had to have completed an international health elective in the past 12 months to be eligible for the study. The authors also stated that the students were white. However, no further information about the sample population was provided. Elit et al. (2011) discussed how the students compared ethical issues of confidentiality and privacy, and how these were addressed in their overseas placement as they experienced patients being examined without measures taken to protect their privacy. They found that confidential information was readily shared with relatives without explicit consent from the patients, leading them to question whether this was acceptable practice in this setting, when it would not be considered so within their home university. The study also found that students raised issues of professional behaviour and acting in a manner to fit in with the expectations of others, but not within their level of competency, and how this would differ in developed countries.

Whilst the literature search highlighted that there is little reported research that focuses on medical students, international placements and medical ethics, there is much more written on the issues and challenges of global health and international placements. Logar et al. (2015), for example, focused on the teaching of ethics through experiential learning and the challenges that global health trainees experience. Logar et al. (2015) explored the ethical challenges that were pertinent for trainees on a global health elective. Some felt that their time in a low-resource country was exploitative of the host population, and that the time spent supervising visiting trainees may have drawn clinicians' attention away from patient care. Further challenges included cultural differences in approaches to care, the significant limits to resources and working beyond their scope of practice and competence. There was little clarity about the type of trainees (i.e. students or junior doctors) in this paper. Ahmed et al. (2017), Law & Walters (2015), Johnston et al. (2017) and Elit et al. (2011) discuss and share the ethical, professional and cultural issues that arise during international elective placements, which include students feeling ill-prepared for the experiences faced on their placements, language barriers between themselves and patients and working beyond their professional competence. Although sharing some similarities to Elit et al. (2011), these authors were not included in the literature review as they did not meet the search criteria.

There is a general consensus amongst authors e.g. Ahmed et al. (2017), Elit et al. (2011) and Maudsley & Strivens (2015), that international/global health electives offer unique learning experiences for medical students. Holmes et a.l (2012:297) state that it allows "students to develop clinical skills in unique and diverse environments." However, despite positivity about elective placements, there are still areas of development to be considered. Authors such as Anderson et al. (2012) and Logar et al. (2015) discuss the need for students to receive pre-departure training in order to prepare for experiences during global health electives. Dell et al. (2014) evaluated the ethics and safety of global health electives placements by exploring the perceptions of medical students. The findings suggest that medical students are ill-prepared in both the safety and ethical dilemmas that may arise, thus arguing that there needs to be a particular focus on complying with clinical limitations and dealing with the emotions that may arise from these experiences (2014, p. 72). Another area

for development is the need to define the educational objectives together with the utility of global health electives (Anderson et al 2012). Jeffrey et al. (2011) argue that despite there being an acknowledgement that international placements enhance the student experience, there is little evaluation of the educational benefits of these components of medical school programmes.

These papers discuss a selection of learners i.e. medical students and junior doctors who access global health elective placements. The nature of the clinical placements discussed in these writings highlight that there are different approaches to how such placements are arranged, including at what stage in training students or doctors access these, and the variation in the length of time spent on their global health electives. Anderson et al. (2012), for example, describe students enjoying a short-term elective placement in a country of lower socioeconomic status. However, students on partner medical school programmes spend 3 years within their international placement in the UK, Canada, Australia or the USA after having spent 2 years in their home country and having had some placements within that setting. Thus, their experience of a global health elective is not comparable to those being discussed by the authors above. This is not a population nor an educational programme which is discussed within the identified literature, thus this indicating a gap in knowledge about the understanding that students on the partner medical school programme have in relation to ethical issues and ethical dilemmas that surface in healthcare and medical practice

Summary

There is a need for further exploration of partner medical school programmes and how the students on these programmes develop their understanding of the ethical dimensions of practice. There is no existing literature that evaluates the content or delivery of medical ethics or the students' perceptions of these programmes. Similarly, there is no assessment as to the efficacy of the delivery of ethics or how the students develop their understanding of the ethical dimensions of practice whilst on a partner medical school programme.

The current literature suggests that there are various debates on the optimal ways of delivering medical ethics, and student perceptions have been captured on the preferable modes of the delivery of medical ethics teaching. In addition, the literature also suggests the need for culturally sensitive medical ethics and not the imposition of one ethical framework. However, although studies have been conducted with Asian student populations, no studies have represented Malaysian students and their experiences of medical ethics whilst on a partner medical school progamme.

Current research is beginning to explore differences in medical ethical culture within the growing context of the globalisation of healthcare, highlighting the importance of improving cross-cultural understanding in successful international medical collaboration (Grol- Prokopczyk, 2013). Literature on experiential learning through global health electives is currently underdeveloped, focusing on short-term international placements as opposed to a long-term international placement as offered on the partner medical school programme. Partner medical school programmes form part of this international collaboration. Existing research in partner medical programmes tends to focus on partnerships between medical schools and local communities in developing countries, with a view to promoting health within the local communities (Nora et al 1994; Busse et al 2014). What the literature demonstrates is that within this body of knowledge there is a gap in the exploration of partner medical school programmes and how the students that undertake these develop their understanding of the ethical dimensions of practice. In addition, there is little research focusing on international undergraduate medical education within the UK. Furthermore, studies by Rothwell et al. (2013) and Hindmarch (2005) have identified needs of an international medical workforce and how to facilitate and support their transition into the UK workplace. Yet, it is worth considering preparing medical students at an undergraduate level to become part of a global workforce through exploring the experiences of students on a partner medical school programme

Existing research explores medical ethical cultures in African (Ypinazar & Margolies 2004: Alkabba 2012) and Asian countries (Miyasaka 1999). However, no research to date has explored Malaysian medical students' experiences whilst on a partner medical school programme and the development of their understanding of the ethical

dimensions of practice. In addition, Malaysian students specifically are underreported within the literature on medical ethics.

Therefore, the aim and objectives of this research are:

Aim: to explore how Malaysian medical students undertaking a partner medical school programme develop an understanding of the ethical dimensions of practice

Objectives

to explore how Malaysian medical students develop an understanding of the ethical dimensions of practice

to investigate factors that may influence or impact the students' understanding of the ethical dimensions of practice

This chapter has provided the reader with an understanding of the context of this research and its position within the existing body of knowledge. It has provided an overview of medical ethics teaching and the main areas of discussion and debate surrounding the teaching of medical ethics amongst the academic community. The literature review has presented the existing knowledge within this subject, as well as some areas for further exploration, and shown how this study contributes new and original data in the topic of medical ethics education. In addition, this chapter has demonstrated how the research aims and objectives were derived from the review of the literature. This study with Malaysian medical students contributes to gaps in our current knowledge in this topic area.

Chapter 3

Methodology

Introduction

Methodology refers to the philosophical stance that guides a study. This chapter presents the philosophical underpinnings of this study and how this informed the approach to selection of participants, study design and conduct of the study.

This research aimed to explore how Malaysian medical students undertaking a partner medical school programme develop an understanding of the ethical dimensions of practice. Addressing this aim required a methodology and related methods that enabled the researcher to gain insight into the participants' experience and knowledge. An interpretive phenomenological stance was adopted in this research. This chapter provides a rationale for the adoption of this methodology through discussion of the qualitative paradigm of interpretivism, the methodology of phenomenology and the works of key philosophers within this field. The final section of this chapter demonstrates how the researcher ensured the integrity of the research, by way of rigour and trustworthiness, when adopting this philosophical approach.

The qualitative paradigm

The qualitative approach was adopted as the principal framework of the study as it allows for the collection of rich data that could be analysed, thereby generating understanding of, and insight into, the research topic. Qualitative research aims to portray the reality or lived experience of the phenomena under investigation and enhance the understanding of that experience (Hewitt-Taylor 2001). Creswell (1998) argued that qualitative research is suitable within the fields of social research, healthcare and education, where participant perspectives and reality are the focus of the research:

> *Qualitative research is an inquiry process of understanding based on distinct methodological traditions of enquiry that explore a social or human problem. The research builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in its natural setting (*Creswell 1998, p. 15).

A research paradigm relates to the components that exist within it, namely - ontology, epistemology, methodology and methods (Scotland 2012). Ontology is an area of philosophy concerned with what constitutes reality and what it means "to be" (Crotty 1998, p. 10). Epistemology concerns itself with the nature and forms of knowledge (Cohen et al. 2007), with epistemological assumptions being concerned with how knowledge can be created, acquired and communicated, in other words *what it means to* know (Scotland 2012, p. 9). Guba and Lincoln (1994) argue that epistemology asks the question what is the nature of the relationship between the would-be knower and what can be known (Guba & Lincoln 1994)?

The interpretivist approach

The interpretivist paradigm is concerned with understanding the world from the participants' perspective, and how "human beings make sense of their subjective reality and attach meaning to it" (Holloway et al. 2002, p. 7). In the statement below, Walsham (1993) captures the main features of interpretivist methodology and its link to the world view (ontology and epistemology) that there are multiple realities rather than one universal and measurable reality, which is associated with positivist research.

> *…interpretive methods of research start from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors. Our theories concerning reality are ways of making sense of the world, and shared meanings are a form of intersubjectivity rather than objectivity* (Walsham 1995, p. 320).

Interpretivism aims to be inductive in its approach to understanding a phenomenon. Interpretivism is, according to Creswell (2008), often combined with the social constructivist approach whereby researchers acknowledge that their view of the world, based on their experiences and backgrounds, will influence their interpretation of a phenomenon. Researchers working within the interpretivist paradigm aim to

make sense of or interpret how others view the world (Creswell 2008, p. 8) by analysing the meanings that people confer upon their own and others' actions and experiences (Thanh & Thanh 2015).

Interpretivist theory developed from the critique of positivism in the social sciences (Cohen & Crabtree 2006), an aims to gather data from the perspective of those experiencing the phenomenon. Phenomenology does not concern itself with tangible facts or realities as they occurred, but in the manner in which those facts/realities are perceived by those experiencing them (Mastin 2008). Stemming from hermeneutics (Geertz 1973), the interpretivist approach was initially focused on interpreting the deeper meaning of text and can be applied to the interpretation of discourse as text. It was proposed by Dauenhauer and Pellauer (2011) that in phenomenological hermeneutics whatever is intelligible is accessible to us in and through language, and all deployments of language call for interpretation. Thus, in line with this viewpoint, interpretivism relies on naturalistic methods of data collection which include interviews, observation and analysis of existing texts (Cohen & Crabtree 2006).

According to Weber (1964), interpretive understanding brought the opportunity to social science research to develop an in-depth understanding of the subjective nature by which individuals observe, interact and make sense of the world. Hughes (1990) suggests that the distinctive characteristics of interpretive understanding means that "human action could be studied in greater depth" (Hughes 1990, p. 92). Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore social or human problems. It allows the researcher to build a complex, holistic picture, analyse words, report detailed participants' views of the topic under study and conduct the study in a natural setting (Creswell 1998). The researcher develops a deep understanding of how the individuals perceive their social world and, as a result, how they understand how they act within it (Hughes 2016). As phenomenology resides within the wider interpretivist paradigm, it is therefore a suitable progression within this chapter for phenomenology to be presented and discussed within the following section.

Phenomenology

Our stance on the nature of knowledge (and reality), particularly whether it is subjective or objective, guides a researcher's theoretical perspective (interpretivist / positivist).

Within the interpretivist paradigm there are a number of identified methodological approaches or traditions. Creswell (2013) discusses 5 key traditions - narrative, phenomenology, grounded theory, ethnography and case study. Of these, phenomenology is the branch of qualitative research most appropriate to address the aims of this PhD study, which aims to explore the participants' experiences of a specific phenomenon, that being the development of an understanding of the ethical dimensions of practice.

Key proponents of phenomenology are Edmund Husserl, Martin Heidegger and Hans Georg Gadamer. Within the broad field of phenomenology different approaches exist across a continuum from description to interpretation.

Husserl proposed that outside observation required a researcher's ability to detach themselves from the observation of the phenomenon and thus exert no influence on the interpretation. Yet Heidegger believed the observer cannot separate themselves from the world and therefore cannot have a detached viewpoint (Mastin 2008). Husserl is described as "descriptive," whereby Heidegger is considered "interpretive" (Reiners 2012). The main contrast between these philosophers is that Heidegger proposes an ontological view that individuals are one with the world around them and it is through this oneness that they understand the meaning of being and existence. Heidegger's view accounted for the researcher's (or observer's) lived experiences as influencing their interpretation and, thus, for a researcher to understand the meaning of the phenomena they cannot disassociate themselves from the research and its participants. Heidegger utilises the term "Dasein" to denote a person's sense of being and engaging in the world around them. From a research perspective, this theory suggests that the researcher is engaged / involved with the research process and its participants through the researcher's own "being in the

world" and having pre-understanding that influenced their interpretation (Horrigan-Kelly et al. 2016).

Gadamer was known for his work within the field of hermeneutics in relation to the interpretation of text. His philosophical outlook shared some features with Heidegger, both in suggesting that experiences or history influences a researcher's understanding of the phenomena, and that the coming together of researcher and participant enables the level of understanding. However, in contrast, Gadamer spoke of a shared reality and understanding of the world through sharing commonalities, including language and historical traditions. In this study a Gadamerian approach was not appropriate as the researcher was not attempting to develop a shared understanding of the world with participants but was seeking to understand how the participants made sense of their lived experiences. Paul Riceour, another philosopher renowned for his work on text, focused on the importance of text as a means of communication and the conveying of messages through time. Ricouer proposed suggestions on the interpretation of texts, developing an interpretation framework as a guide to the interpretation of text. Throughout the chapter, discussions on the views of these philosophers and their work will be presented. However, this research relied heavily on the philosophical works of Heidegger and this is evident from the data collection process through the analysis and interpretation of the data.

Hermeneutic phenomenology

Hermeneutics is a methodology of interpretation, with Ezzy (2002, p. 24) defining it as "the art and theory of interpretation." The term itself originates from the Greek word "Hermes," meaning messenger (Ghasemi et al. 2011). Thus, in hermeneutics, the researcher is deemed to act as a messenger between the research and the reader (Palmer 1969).

Paul Riceour was the first to amalgamate hermeneutics and phenomenology into the one philosophy of hermeneutic phenomenology. The overriding principle of hermeneutic phenomenology is that our basic view of the world (as individuals) is full of meaning and that we are one with that world (van Manen 2014). Thus, the aim of

hermeneutic phenomenology is to "bring to light and reflect upon the lived meaning of this basic experience" (Goble & Yin 2014), therefore there is concern with human experience (Kafle 2011). According to Smith (1997, p. 80), "it is a research methodology aimed at producing rich textual description of the experiencing of selected phenomena in the life world of individuals that are able to connect with the experience of all of us collectively." Smith (1997) captures both Goble & Yin's (2014) and Kafle's (2011) perspectives in the definition above, and describes what has been applied in this study, whereby the understanding of the lived experiences of the sample population was developed through analysis and interpretation of texts in the form of interview transcripts.

Adopting Heideggerian philosophy in the study

Hans Georg Gadamer and Martin Heidegger were both prominent philosophers within hermeneutic phenomenology. However, the Heideggerian philosophy was adopted throughout the study from data collection methods through to data interpretation process.

Setting the scene in data collection

Pre-existing knowledge of the sample population ensured that the researcher created a suitable platform in which they could express themselves openly and honestly. Knowledge of the participants' cultural norms raised challenges for the researcher, as their cultural ideologies result in an obligation to respect figures of authority such as teachers (Amirkhiz et al. 2012). As a tutor for the students, the researcher was in a position of authority, thus the challenges to be negotiated were that of the reverence bestowed upon individuals in such positions and the notion that those in such positions are correct and that their instructions should be followed. The researcher therefore created an environment whereby the participants would not be concerned as to whether their responses were right or wrong. This was achieved by commencing the interviews with an opportunity for the participants to discuss their backgrounds and their individual perspectives. The intention was to create an opportunity for the participants to become comfortable within the interview setting

and develop trust with the researcher. As such, there was genuine concern to get to know them as individuals with unique backgrounds and experiences. Heidegger argued that Dasein, or "being in the world", is relative to context (McConnell-Henry et al. 2009). Therefore, to understand the participants' reality a contextual backdrop to their lived experiences was established.

Data collection

In this study, the use of semi-structured interviews allowed for the researcher to become involved with and respond to the participants. The use of an interview guide in contrast to structured interview questions aligned with the ontology of Heidegger's philosophy as it enabled the exploration of how participants understand the reality of their lived experiences.

The researcher was engaged in the dialogic process via synergistic communication with the participants (Russell & Kelly 2002). The subjectivity from both the participants and the researcher enhanced the research process. However, reflexivity is important within this process; a need to ensure that the researcher's viewpoint is not superimposed onto the participants and that their understanding of the phenomenon is the focus of the interview. The interview guide provided a means by which to ensure consistency whilst allowing flexibility for some relevant digression and expansion on responses. Participants were encouraged to expand through the use of silence, clarifying questions, e.g. "*Could you explain what you mean by that…?*", or prompting questions, e.g. "*Could you tell me a little bit more about that…?*"

The interpretive framework

The strategy involved in data interpretation needed to stay true to the Heideggerian philosophy and the phenomenological methodology. An adaptation of Hycner's (1985) data explication process was applied as it complemented Heideggerian philosophy. Familiarisation was a key step in Hycner's (1985) process and, as

discussed above, is key to engaging with the data. This framework supported the researcher in keeping with the data through the interpretation process. The process, which is further discussed in Chapter 4 Methods, enabled the researcher to stay close with the data, through reading and re-reading, line-by-line analysis and generating codes.

Transcription of interviews

The transcription process aimed to capture the mood of the interviews and the individual characters of the participants with the aim of providing context. The interviews were transcribed verbatim, utilising the words used by the participants to express themselves. As international students, they demonstrated a unique manner in which they expressed themselves in English. However, staying close to their words offered a degree of authenticity to the data collected and depicted a level of authenticity in the relationship between the researcher and the participants, particularly where it captured a dialogue. This approach also stayed true to the participants and allowed for the Dasein to be revealed within the study (McConnell-Henry et al. 2009).

According to Heidegger, Dasein is never devoid of mood or disposition and "the starting point is always the mood in which the experience is lived" (McConnell-Henry et al. 2009, pp. 7-15). Therefore, in addition to providing context, the mood was captured through the inclusion of pauses, sighs, laughter, non-verbal gestures and other expressions that would bring the transcripts to life and re-create the essence of the interview as "the interview transcripts as the only concrete link to the participants' expression of their experience" (Tan et al. 2009, p. 7). Recording such nuances enables to researcher to maintain a closeness with the data, although Ricoueur (1981) poses the notion that the inclusion of such expressions does not prevent distanciation between the researcher and the text.

Ricouer (1981) speaks of distanciation occurring as a part of the move from speech to text, in which a distance is created between the researcher and the original discourse whereby the richness and character brought through non-verbal cues is lost, leaving the text as the only account of the subjects' lived experiences (Tan et al.

2009). Heidegger's position is one whereby the researcher is "one with the research", and in adopting this approach the researcher in this study transcribed the interview they had conducted. This approach reduced the level of distanciation that Ricouer (1981) argues exists in the conversion of speech to text. In addition, the process of transcription enables the researcher to "own" the text (appropriation) through familiarisation (Ricouer 1981), a feature shared with Heidegger's approach. A greater level of engagement with the data was also achieved through multiple readings of the transcripts. Familiarisation formed part of the data explication process adapted from Hycner (1985) and presented in the methods section.

Reaching interpretations

The researcher's inability to disassociate themselves from the research when working within a Heideggerian methodology has been discussed. The researcher acknowledged this when analysing the data by posing 2 questions:
- What is the text saying? This relates to the words on the page.
- What is the text telling us? This relates to the ideas and messages that are being conveyed by the text.

According to Horrigan-Kelly et al. (2016) this questioning allows the researcher to place themselves in a position of neutrality, whereby their pre-understanding and knowledge does not influence their analysis and interpretation of the data.

This research aimed to explore and understand specific experiences by a specific sample population, at a specific point in time. Their perceptions of reality would have been influenced by time and experience, with the same being true for the researcher interpreting the data at that point. In this study, the sample population were selected from the same partner medical school programme, in the same year of study and based at the same hospital.

From the Heideggerian perspective, the understanding and interpretation of a phenomenon is gained through shared knowledge and shared experience (Reiners 2012). Welch (1998) shares a similar view, suggesting that in order to understand

something (a phenomenon) we become involved and, as we become involved, we understand. Through the use of the same interview guide, revisiting the same topics and listening to each participant until no new knowledge was collected (saturation), the researcher became involved and engaged with the data, and developed an understanding of the participants' lived experiences. This lack of disassociation between the researcher and the research enabled the researcher to understand the meaning of the phenomena being studied.

Time and interpretation

Temporality may result in a variation in the level of analysis, and the realisation that other meanings lie within the participants' discourse, when the data is revisited at a later date. However, while Heidegger (1961) poses a multidimensional view of the definition of truth he does not pose a definitive definition. Heidegger (1961) promotes the idea that truth is an "unconcealment" or uncovering. What is therefore "uncovered" through the analysis of the data, irrespective of the point in time in which it is done, and should it therefore be considered as truth? In adopting this approach the researcher acknowledges that there may exist more than one truth or reality. This is not a criticism of the interpretation of the data but an acceptance that there can exist more than one interpretation as part of Heideggerian methodology. In addition, the meaning of these experiences were viewed in the wider context, and their place within the wider literature, through the literature review. Through demonstrating a rigorous process of data analysis and interpretation, the researcher is able to demonstrate that the interpretation (and multiple interpretations) can be accepted as a true reflection of the participants' experiences.

In the context of phenomenology, it is possible that there does not exist one reality. This is not to say that what is being presented at a given time is not true, it is simply true for *that* (Malaysian medical student) population, at *that* (year 5 of a medical degree) time, experiencing *that* (a PMSP) phenomenon. Those external to these experiences may be unable to challenge the truth behind the reality of the participants' lived experiences, as each will have their own personal understanding of events and their own perceived reality.

Privileging the participants' views

Knowledge of the participants' backgrounds allowed for understanding of their experiences from their viewpoint and developing an empathy of how and why they perceived their reality in the way that they did. Using the participants' own words in the transcription process and not Anglicising their voices gave way to seeing the world through their eyes. In addition, clarification was sought throughout the interviews when points were unclear to ensure that their perspectives had been captured.

However, the researcher had their own personal experiences of being an international student with a command of two distinct languages and originating from a unique culture, and thus shared an understanding of the participants' experiences of learning within a culture different from their own. This is supported by Heidegger's theory of "being in the world", whereby through our self-awareness with regard to our feelings and expectations about our research we fully appreciate the nature of our investigation (Shaw 2012). The use of peers through a supervision team to discuss these interpretations offered a platform by which the researcher could have their interpretations challenged, and ensured that the interpretation did not extrapolate beyond the data.

Reflexivity

Guided by the Heideggerian philosophy, being reflexive explores and uncovers the researcher's pre-understanding and its influence on the interpretation of the participants' reality. Acknowledging this fact and invoking the use of critical friends aided the process to ensure that interpretation did not extrapolate beyond the data. Becoming familiar with the data through listening to the interviews, conducting the transcriptions and undertaking multiple readings of the text, enabled the researcher to become fully immersed and engaged with the data. It is through this engagement that the researcher was able to develop a deep level of understanding of what the participants had said.

Rigour

Areas of consideration in research methodology include issues of reliability, validity, trustworthiness, authenticity and bias. From a Heideggerian perspective, these challenges are not considered bias or prejudgment but more of a pre-understanding of the world. This pre-understanding related to the lack of detachment which exists between the researcher and the research. Further to this, the Heideggerian approach acknowledges this influence of the researcher as an integral part of the research, with this lack of disassociation between the researcher and researched enabling the researcher to understand the meaning of the phenomena being studied and being an appropriate vehicle for interpretation (Ricouer 1981). The understanding of the text comes through the knowledge which stems from the researcher's subjective experience of the data being analysed (Palmer 1969). Through acknowledging this subjectivity, the researcher offers transparency to these aspects of the guiding philosophy and brings rigour to the study through the process of reflexivity.

A detached viewpoint denotes objectivity, yet the degree of detachment is something that is debated when discussing research methodologies. Maier & Monahan (2010) discuss when being close to the research is considered too close (in qualitative research), but they are unable to draw a definitive conclusion to this question. Dreyer (1998) speaks of detached researchers not standing outside of the research relationship, and thus bringing their experiences of the world to the research through the sharing of the same epistemological framework (Dreyer 1998, p. 16). In this PhD study, such an approach would result in the loss of context to the data, and thus a loss of meaningful interpretation and the richness that comes with qualitative research. Due to the nature of interpretivist research, the possibility exists that different interpretations can be achieved. Yet qualitative research includes reflexivity as a means of reducing issues such as bias. Creswell (1998), provides a critique of the processes applied within research, such as data explication and interpretation.

Trustworthiness

Qualitative research includes various research designs, using methods and methodologies that allow for the investigation of the human experience. Criticisms of qualitative research refer to a lack of reliability, validity and generalisability, via issues such as researcher bias, inaccurate representation of the data, the inability to replicate the results and lack of applicability to a wider population (Gibbs 2007). However, qualitative research is not measured with the same criteria adopted within the quantitative paradigm, thus the above parameters stated by Gibbs (2007) are inappropriate for this study, and according to Gholafshani (2003) there is a need to redefine these terms for the purposes of the qualitative researcher. Creswell (1998) and Begley (2003) state that in qualitative research reliability and validity are typically described as credibility and trustworthiness, and it is through these that rigour is demonstrated.

Summary

This chapter has provided an overview of qualitative research, interpretivism and phenomenology and their suitability to address the aims of this study. This chapter acknowledged the qualities of this methodology but did not fail to address areas that are often subject to criticism from those assuming a positivist approach. However, this chapter has offered discussions supported by authors such as Creswell (1998, 2008, 2013), whose definition of qualitative research illustrates its suitability for research involving the human experience. This makes it an optimal approach to be adopted for this study, demonstrating that qualitative research offers an alternative and more flexible approach to research, but one which is still bound to processes of rigour and critical analysis.

Interpretivism was defined as the overarching philosophical principle underpinning the research. It defined the position of the researcher within the study as an observer of the phenomenon, offering an interpretation of the subjects' lived reality to the

reader. Phenomenology was presented as the qualitative approach adopted within this study. A discussion was offered illustrating its connection to hermeneutics and influential philosophers such as Husserl, Heidegger, Gadamer and Ricouer, and how their works supported the use of data collection methods such as interviews and transcriptions, as well as the position of the researcher within the analysis and interpretation process.

The Heideggerian philosophy which guides this research was presented and linked to the strategies used within the study. This chapter showed the distinction between the influential philosophers and how this research linked closely with the Heideggerian approach in contrast to others. It clearly demonstrated how this philosophical approach was linked to the data collection and interpretation methods used within this PhD study, which are discussed in the following chapter

Chapter 4

Methods

Introduction

Having presented the methodology informing this study, this methods chapter will describe the journey navigated by the researcher from developing the initial idea and expressing it as a research question, through to analysis and interpretation of the data. It was important to ensure the methods used in data collection and data analysis processes were suitable to address the research question, and meet the aims and objectives of the research, as a result of the interpretive methodology.

Research design

The research design should address the research question clearly and unambiguously to ensure that the evidence gathered enables the researcher to undertake this effectively (Labaree 2013). The research design for this study involved a single stage of data collection. One interview was undertaken with each participant, and all interviews occurred within the same locality. The participants were recruited at the same stage from within the final year of the MBChB programme to ensure that they had completed their initial medical education in Malaysia, together with both core and optional specialty placements in healthcare settings in the UK. Hence, they would have had clinical experiences that they could consider during the interview process.

The study site

The NHS hospital trust was selected and recruited to this study because it was guaranteed that students with experience of the phenomena being studied would be on placement at that location. The hospital trust (which includes hospital and community NHS services) provides medical education for approximately 80 of a total cohort of 450 students each year. At any point in time there are approximately 240, years 3-5, medical students working in this hospital trust. At the time of this study (2010-2014), from a total of 240 medical students, approximately 18-30 of these were Malaysian students.

Sampling strategy and the recruitment process

A purposive sampling strategy was used to select participants with relevant experience to address the research question. A purposive sample is derived from a population that has knowledge of the subject of interest (Creswell 2013; Silverman 2001). According to Creswell (2013):

> *It is essential that all participants have experience of the phenomenon being studied. Purposive sampling demands that we think critically about the parameters of the population we are interested in and choose our sample case carefully on this basis* (Creswell 2013, p. 155).

The inclusion criteria for the participants selected as part of the sample were:

- Malaysian-origin and Chinese-Malay descent medical students registered on a partner university programme
- Students undertaking clinical years only in the UK
- Students in Year 5 of the medical MBChB programme

Exclusion criteria

- Medical students of Malaysian origin but had not completed a partner medical school programme.

In this context, the term *Malaysian student* refers to students who were born and had lived in Malaysia for most of their lives before entering the university in Malaysia. The study focused on individuals whose first experience of the UK was at the point of entering the medical programme in year 3. The challenge within this project was to ascertain which students were of Malaysian origin. Students who attended the university in Malaysia, but were not of Malaysian origin, would have had different experiences that may have influenced their understanding of ethics and how they

approached moral dilemmas that arise in clinical practice. These individuals would not meet the inclusion criteria.

Twenty-five students were invited to find out about the study, and 17 responded indicating their interest in participation. Of these respondents, one was not eligible to take part. Sixteen 5th year medical students were recruited from 3 academic years, 2011-12, 2012-13, and 2013-14, with 4, 4 and 8 students from each cohort respectively. Age ranges were between 22-24 years and there were 7 males and 9 females. Six of the participants were of Malaysian origin, with the remaining 10 being of Chinese-Malay descent. Their educational backgrounds prior to commencing the university programme were varied. Some of the participants had attended private schools, whilst others had attended state-run schools. Three of the Chinese-Malay students had attended Chinese schools in Malaysia, whilst others had attended schools which included a body of students comprising of Chinese, Malays and those of other ethnic origins. All participants had been taught English from primary school age of approximately 4 years (see Table 5).

Table 7 Characteristics and distribution of Malaysian students within the student population from 3 cohorts 2011-2013

		Age		Total invited		Gender			
		21-24	25+			Male	Female	Chinese	Malay
Total Number of students	240	237	3	-		105	135	-	
Home students	190	187	3	-		90	117	-	
Malaysian (Malay and Chinese-Malay)	25	25	-	25 (16)*		10 **(7)***	15 **(9)***	14 **(10)***	13 **(6)***
Other	25	25	-			4	4	-	

*denotes participant numbers

Year 5 students were chosen as they have a greater experience of both the course and clinical exposure in the UK in comparison to students in other year groups. They were also at a stage in their education in which they were consolidating their competencies in preparation for clinical practice as qualified practitioners. Thus, at this level all the participants would have completed taught modules concerning medical ethics and would have had a minimum of three years of clinical experience within various clinical settings. During these placements they would have encountered ethical issues and dilemmas.

The recruitment process

Potential participants were initially approached via email to ensure that they were informed about the study without direct contact from the researcher, who was a member of staff and tutor at the hospital where they completed clinical placements. This approach minimised coercion and optimised the potential participants' opportunity to decline participation.

Recruitment commenced in April 2012. Following commencement of recruitment, it became clear that several factors influenced recruitment and subsequent attendance at interviews. These included undertaking elective clinical placements and completion of assessments at the end of the academic year prior to graduation. Careful planning was required for subsequent recruitment to ensure that potential participants were invited to the study at an optimal time within the academic calendar when students did not have significant demands that they had to prioritise over participation in research.

Initial data collection occurred in May 2012, with 6 students agreeing to participate, but only 4 students attended the interview. The aim for the second round of recruitment was to recruit during the first semester in year 5, when all students would be available, as opposed to semester 2. Three eligible students responded and due

to slow progress with recruitment the following changes were made to the approach to recruitment:

- Other hospitals affiliated with the medical school were approached and asked to forward the information about the study to their year-5 Malaysian students.
- Whilst the students were in year 4, a presentation was given to the whole cohort to inform them about the study prior to recruitment in year 5.

The change in approach led to recruitment of 4 participants between Jan-June 2013, and 8 during December 2013 to May 2014. Consequently, 16 participants agreed to participate in interviews during May 2012 - May 2014. Table 6 presents demographic information of each participant who took part in the study.

Table 8. Participant demographics

Name*	Gender	Age	Origin	Interview Type
Lutfi	Male	23	Malay	Focus Group (FG)
Naseem	Male	24	Malay	FG
Eu-Meh	Female	23	Chinese-Malay	FG
Pei-jing	Female	23	Chinese-Malay	FG
Hai	Male	24	Chinese-Malay	Individual (I)
Nadia	Female	24	Chinese-Malay	I
Kueng	Male	24	Chinese-Malay	I
Alwi	Male	24	Malay	I
Sarayah	Female	24	Malay	I
Guan-Yin	Female	24	Chinese-Malay	I
Cheng	Male	24	Chinese-Malay	I
Liwei	Male	24	Chinese-Malay	I
Ibrah	Female	24	Malay	I
Samyyah	Female	24	Malay	I
Lian	Female	24	Chinese-Malay	I

Jia	Female	24	Chinese-Malay	I

*all names are pseudonymised

Issues of recruitment

Recruitment was impacted by non-response to the invitation, distance of regional or overseas placements, and willingness to participate but not being available for interview. Eligible students on overseas placements did not have regular access to emails, and this delayed their response to the invitation to participate, which in turn hindered the recruitment process. The alternative approach of making a presentation to the whole student cohort provided a way of raising awareness of the study without targeting students individually.

Recruitment in the academic years 2012-2013 and 2013-14 took place in semester one. Difficulties existed in recruiting enough participants to hold focus groups as initially planned, therefore data collection methods were amended to include individual interviews in order to optimise the collection of data.

Sample size

Sample size cannot be pre-determined. In qualitative research, more participants do not necessarily result in more or new data (Mason 2010). In qualitative studies sample sizes can be determined by adopting the concept of saturation, which is the point when collecting new data does not shed new insight to the research question (Glaser & Strauss 1967). Guest, Bunce, and Johnson (2006) propose that in homogenous groups (i.e. groups that are in a particular position or situation) saturation often occurs around 12 participants. Latham (2015) supports this approach and argues that within most qualitative studies involving homogenous groups, 15 participants is often considered to work well. Conversely, if the sample is too large, then the data becomes repetitive and superfluous (Mason 2010). The aim in this study was to build and maintain a close relationship with the participants in order to facilitate an open and honest exchange of information (Crouch & McKenzie 2006), which aligns with the interpretive methodology adopted in this study.

Data collection

The approach to data collection sought to create a situation in which the participants felt freedom and security to express their thoughts and feelings and share their lived experiences of the medical programme in both the UK and Malaysia. A particular focus was the exploration of the reality of their professional lives and their perceptions of the ethical dimensions of clinical practice. To gain an insight into these phenomena, methods were utilised that enabled the participants to describe and explore their experiences. Methods included semi-structured individual and focus group interviews. These data collection tools are appropriate when adopting an interpretative methodology, as the qualitative research interview is a vehicle that supports the interviewee to describe their experiences and the meanings associated with those experiences. In total, one focus group interview and twelve individual interviews were conducted.

Interview types, benefits and limitations

The main task in interviewing is to understand the meaning of what the interviewees say and Kvale argues (1996, p. 45) that interviews "are particularly useful for getting the story behind a participant's experiences." The interviewer can pursue in-depth information around the topic (McNamara1999). Semi-structured interviews include open-ended questions, offering a degree of flexibility to follow topics that emerge through the interview process. They allow for the collection of rich, in-depth accounts and exploration of views and experiences through following a guidance framework (see Appendix H) to ensure that participants provide data within the scope of the research question and address the aims and objectives. Semi-structured interviews are distinct from narrative interviews, in which participants are in control of the information imparted during the interview. Narrative interviews often start with one question, with the participant then telling their story in response to this question (Stuckey 2013). These types of interviews are unpredictable and produce large amounts of data which may not always be relevant, and in addition can make data analysis difficult due to the breadth and depth of themes generated (Stuckey 2013).

In this study the interviews were planned to provide an opportunity for participants to express their ideas on the phenomenon, whilst providing context to their discussion through the inclusion of some personal biographies. The interview guide provided a fluid structure by which the focus of the study was maintained. The following section presents the benefits and challenges of individual and focus group interviews.

Focus group interviews

Focus group interviews are commonplace in areas where a qualitative methodology is applied to add richness to the data (Kvale 1996; McNamara 1999). Participants are selected based on their knowledge of the subject of focus, share similar characteristics and would be comfortable relating to each other (Rabiee 2004). The advantages to using focus group interviews include the self-perpetuation of discussion due to the interaction between participants, which "often leads to spontaneous and emotional statements about the topic being discussed" (Kvale 1996, p. 101). Such interactive discussions can rouse thoughts and memories amongst the group that may have been forgotten and offer a multi-dimensional view of specific events. The recommended number of participants within a focus group interview varies, with suggestions between 5 and 8 individuals (Marrow 1996). Some authors, such as Gibbs (1997), advocate the use of smaller group sizes, especially when conducting interviews with minority groups who may feel more comfortable engaging in a discussion in a less public forum. However, too few individuals in the group could result in a lack of diversity and imbalance between group members, where a more outspoken individual could dominate the interview. Gill et al. (2008) and Kitzinger (1995) also support the use of small groups, and these authors argue that small groups can allow for more in-depth data as opposed to larger groups, whereby the interviewer may be required to act as a moderator in order to retain the focus of the discussion.

A disadvantage of focus group interviews is the inability to anticipate the workings of the dynamics within a group. Thus, ground rules are often set within focus group interviews in order to minimise one individual dominating the discussions and ensuring respect for the contribution of each member of the group.

In this study normative issues pertaining to social/cultural factors were considered in the conduct of the focus group interviews. In some cultures, such as Malaysia, females are not encouraged to discuss and/or debate issues with males, and this could have hindered the flow of the interview. Rodriguez Del Pozo & Fins (2005) commented on how in some cultures it is not considered a positive attribute to make a fool of oneself in public. This could have impacted on the degree of contribution and discussion of participants if they did not wish to appear foolish in front of their peers when discussing the challenges and concerns that they had about their experiences in clinical practice.

The first interview consisted of a focus group interview with four participants. Although this represents a small number of participants for this particular method, a pragmatic decision was made to proceed as these individuals were keen to take part in the discussion. Whilst the group was small, this interview allowed for greater depth of discussion between the participants, with each participant's contribution sparking further contributions from their fellow students. The participants were invited to discuss their experiences throughout the programme, which had occurred in two countries as part of the PMSP. The participants were not asked to compare experiences but to explore their experiences with regards to their understanding of the ethical dimensions of practice.

During the 2 hours of the interview the participants willingly contributed and shared their experiences and perspectives. Much of the discussion was self-initiated, and discussions flowed from one into another quite fluidly. An example is provided below, where the participants were discussing their experience of studying in the UK. Questions were posed to clarify the researcher's understanding in response to their discussion in order to encourage the participants to elaborate on the issues that they had raised. In the example below, the researcher attempted to clarify one participant's comments through questioning and this prompted another participant to add to the discussion.

Pei-Jing - … The nurses in the UK they can do venepuncture errr, they can put in cannulas, they can administer controlled drugs and all that. The ones in Malaysia are kind of limited, they can't take bloods they can't put in cannulas, it's all on the doctors. So the workload on the doctors is incredible in Malaysia. They have to go in very much earlier, do all the necessary jobs, take the necessary bloods before the ward round starts….

Researcher - So the nurses don't have the same autonomy as they do here?

Pei-Jing - No they don't.

Eu-Meh - I got a different experience though. Because I worked, not really worked, I helped out in A&E and the nurses are very good. There are a few of them, like sisters, who are allowed to do cannulation, venepuncture, catheterisation… even PR and Echocardiograms …

A difficulty with the focus group discussion was that at times it is difficult to hear all contributions within an audio interview when there is more than one participant contributing. Although ground rules had been established with regards to respect for others' contributions, there were a few occasions when, due to the participants' enthusiasm, they all spoke at once. In addition, there exist practical issues in organising focus group interviews. The running of focus groups is dependent on the recruitment of an appropriate number of participants, with this being reliant on the availability of these participants at the same point in time, as well as ensuring that a suitable venue is acquired and all participants can attend. Therefore, although focus groups are a good data collection method, they require a number of suitable variables to ensure they can take place. Individual interviews were advantageous in terms of practicality, as meeting with one individual was easier than arranging an interview with 5 or 6 participants. This lowered the risk of attrition in the study because it was more feasible to accommodate each individual participant's preferred date and time for the interview.

Individual interviews

Other advantages of conducting individual interviews were not having more than one participant talking at the same time and decreasing the possibility of difficult group

dynamics. Yet, in individual interviews, the interviewer had to undertake a greater role in facilitating the discussion, and this required a different set of interviewing skills.

Individual, in-depth semi-structured interviews are used in order to capture rich, detailed data. Semi-structured interviews involve the use of a topic guide that is generated by the interviewer, and based on the aims of the research question rather than formulaic questions. This guides the interview with questions and comments (see Appendix H). In addition, these types of interviews allow the researcher to have a high level of engagement with the participants. This is consistent with Heidegger's philosophical stance which has guided this research, whereby the researcher cannot be fully dissociated from their work.

According to DiCicco-Bloom & Crabtree (2006), allowances for digressions from the planned itinerary were made, and these digressions were very productive and added richness to the data collected. This is supported by Downs (1999), who states that "the interviewer who insists upon strictly following a prepared list of questions instead of following the respondents' beliefs of what is important usually produces less genuine results" (Downs 1999, p. 87). Thus, "good qualitative research requires a flexible interviewer" (Downs 1999, p. 87).

The aim of the interview was to explore the students' reality of their experiences, and their perspectives on how they become aware of and learn about ethical dimensions of practice within their clinical placements throughout their medical degree. This involved becoming familiar with these individuals, with a view to gaining better understanding of their lived experiences as part of the interpretation process. Interviews commenced with discussion about the participants' biographies, thus enabling familiarisation with them, their experiences, preferences and interests, including discussion of their initial experiences within their education system, from primary school to university. Other issues explored were upbringing, religion, and family relationships, all of which had an impact in shaping these individuals'

understandings of the world. These discussions also provided an abundance of information about their lives. Below is an extract from an interview depicting the open questioning style used to explore the participants' perspectives and experiences.

> *Researcher - Tell me about [the name of your university].*
>
> *Keueng - [The name of the university]… well I can't really remember what made me go into medicine in the first place. I wasn't good at physics. I was interested in becoming a pilot but… my eyesight, I can swim, but I wasn't going to become a pilot or an engineer, and my Dad's a GP so I thought, "Ooh maybe it's in the blood", so I went for an interview. I couldn't remember much… it was two lecturers interviewing me. Before that there was a long application process, had to get an apartment for rent to go to interviews. Then going to [The name of the university]… yeh it was ok, although our batch had about 2… 200 to 250 applicants who came on the first day so, they err orientate us on the first day, they gave us lab coats, they put us on stage, had a group photo…*

Interview flow relied heavily on the researcher's ability to listen actively, but also to utilise the information provided as a prompt to initiate further discussion should the conversation cease. This was at times achieved by summarising what had been discussed until that point in the interview. This technique was useful in cases where there were long silences and the interview appeared to have stalled. However, pauses or silences are often deemed as an important and useful part of an interview, allowing for thought and reflection, and is advocated by some researchers such as Gill et al. (2008), who stated that:

> *The strategic use of silence, if used appropriately, can also be highly effective at getting respondents to contemplate their responses, talk more, elaborate or clarify particular issues* (Gill et al. 2008, p. 292).

This is a technique also utilised in medical interviews (Silverman et al. 2003). Through the use of supportive gestures and active listening techniques such as nodding, the participants were encouraged to reflect and elaborate on their points throughout these silences.

Issues of language

All the participants had achieved tier 4 level in spoken English and were able to articulate ideas within the context of the interview, although there existed variations in the use of vocabulary. Language was initially considered an issue in the data collection process. Yet students' expressive use of language created a sense of individuality and captured the reality of their lived experiences. Palmer (1982), for example, argued that language shapes how man views himself and the world, as his vision of reality. In the example below, Hai describes the issue of confidentiality. It can be seen how his ideas regarding confidentiality can be understood, but it is the structure of his statement and his use of language that portray his individuality.

> *Hai - That is the main thing that is different from here. Here, like if you yourself had any disease, if your sons or daughters or your wife want to ask about it, from the doctor cannot break confidentiality because of the patient's own autonomy. In Malaysia, errm no, the whole family. If anyone, the relatives can answer, he got this. Yeah. That is the main confidentiality difference.*

As part of the interpretive process, the researcher had to decipher the meaning of the participants' experiences through the language they used. This involved re-reading the transcript in order to understand the context of what was being said, and therefore reach an appropriate interpretation of their lived experiences.

Disadvantages of interviews

A shortfall of audio recording of the interviews was the inability to capture facial expressions, hand gestures and other body language, especially between members of the group, as these may have been an indicator of feelings related to the dialogue. Other issues included the difficulty in recording individuals with strong accents, which at times made transcription difficult, as some words were difficult to decipher.

Table 9. Steps to thematic analysis

Steps in the interpretive process of the study	
1) **Transcription**	The audio recordings were transcribed verbatim, noting non-verbal elements of the interviews
2) **Open coding**	Familiarisation - is the process of becoming acquainted with the transcripts and knowledgeable about their content including key words, phrases and topics discussed Listening to the whole interview to capture a sense of its overall meaning Delineating (or portraying) units of general meaning Delineating units of meaning which directly relate to the research question Eliminating redundant codes
3) **Thematic development**	Clustering the units of relevant meaning Determining themes from clusters of meaning Contextualising themes Writing up and presenting the contextualised themes as findings

The amount of data collected from interviews can be abundant. Although this is beneficial to the researcher (as data is central to the study), it can however result in difficulties in handling large amounts of data. Although digression, as stated by DiCicco-Bloom & Crabtree (2006) and Downs (1999), adds to the richness of the data, such digressions could potentially generate data that digressed too far from the research topic, resulting in the transcription of additional material which would only serve to burden the already time-consuming process of interview transcription.

Explication and interpretation of the data

Explication implies "an investigation of the constituents of a phenomenon while keeping the context to the whole" (Hycner 1999, p. 161.) According to Tesch (1990) and Creswell (2009), this process is eclectic and there is no one right way of conducting this process, which can take many forms that can be adopted for different types of designs (Creswell 2009).

Transcription and explication

From speech to text – transcribing the interviews

All the interviews, both focus group and individual, were audio recorded, which ensured that the words, expressions and silences were captured. The recording allowed the researcher to listen to the interviews at a later date and enabled verbatim transcription of the interviews. The audio interviews lacked any of the visual elements, such as facial expressions and hand gestures, that correspond to an interaction between individuals. A challenge of interview transcription is that the position of commas, full stops, and other symbols of punctuation are left to the discretion of the researcher. When listening to audio recordings, it is often unclear where sentences begin or end. The researcher's position therefore has the power to influence and shape the meaning. However, having been involved in the data collection process the researcher is also in a position to have insight and be intuitive enough to present the meaning of what is being conveyed by the participants.

Kvale (1996) recognises these challenges and argues that there is no correct transcription, because there is no correct transformation from verbal to written discourse. Such statements can be viewed as challenging the place of transcripts as data within qualitative research, but what Kvale (1996) conveys is the need to recognise that differences can exist within this process. Thus, although the audio recording exists permanently in its original format, the transcription itself may differ depending on the individual transcribing it. Kvale (1996) states:

> *Transcripts are not copies or representations of some original reality, they are interpretive constructions that are useful tools for given purposes* (Kvale 1996, p. 165).

Here, Kvale (1996) argues that the purpose of transcriptions (rather than their format) is the overriding principle in the process, with the researcher ensuring that the transcription is aligned with the aims and objectives of the research.

The researcher applied the following guidelines to all (focus groups and individual) interviews transcribed:

- Anonymity of participants and other persons mentioned was maintained with only pseudonyms utilised and entered in the script
- Transcribing the interview as a whole
- Inclusion of non-verbal expressions such as laughter in the text
- Noting pauses
- Entering in the text whether the discourse was difficult to understand, inaudible, or in the case of the focus group interview if more than one person was talking
- Using the participants' exact language – some participants did not often have the correct English term for an event/action etc. and the words they used to describe what they were trying to convey was used exactly in the manner presented by them and may appear as spelling mistakes e.g. in his interview Alwi uses the words "womens and womans" interchangeably as the plural of woman, and not to denote possession as in "woman's/women's".

To capture the essence of the interview, pauses in speech, whispers or laughter were recorded (Kvale 1996). These were significant in adding richness to the data collected, and a greater sense of the reality of the participants' lived experiences. As the interview was transcribed it allowed for the researcher to become familiar with the narrative and get a real feel for the mood and essence of the interviews. Although within the interviews there were no emotive episodes, such as exhibition of anger for example, there were gestures and expressions that captured the feel of the conversation and the personality of the participants. The example below captures the moment when a participant had shared an experience that she had not recalled for some time.

> *Nadia - (whispers and holds her hand to her mouth with a mischievous expression) I completely forgot about that. But that was the most interesting part of my entire life… seeing people like that.*

This type of gesture suggested that the participant felt that the events she described were not ones that she should have forgotten, and the whispering and hand over the mouth gesture is symbolic of not wanting to outwardly portray that she had not recalled this experience. The expression, however, also presents Nadia's sense of humour and this adds to what is conveyed in her statement.

In places, lack of clarity and fluency made transcription difficult. It resulted in having to listen to parts of the interview repeatedly to ascertain what had been said. At times this was extremely difficult or impossible, and led to noting on the transcript "difficult to understand". The example below is taken from the first interview.

> *Lutfi - They are very, very strong, how else would we have survived (says something which is difficult to understand). In terms of discipline, they are pretty disciplined. They can take care of their lives, in terms of patients and medication, they don't go wrong.*

In the above, Lutfi was mumbling at times and this made it difficult to interpret what he was saying. This also added to the amount of time it took to transcribe the interviews. Lack of fluency also added to the transcribing process, as there were pauses and repetition of words and even sounds, all of which were included in the transcript.

Immediately after each interview, the researcher reflected on the event, capturing initial thoughts and feelings about the interviews, which involved:

- The researcher's impressions of the main points covered in the interview
- Impressions of having acquired new information
- Points which had not been previously considered

Open coding

Familiarisation

The process of familiarisation allowed the researcher to generate an overall impression of the main topics that the students spoke about. This was achieved by the researcher immersing themselves in the data, by reading and re-reading the transcripts (Braun & Clarke 2006; Hycner 1985). From reading the transcripts the questions at the forefront were, "*What is the meaning of this text? What is the meaning of the whole discussion?*" Notes were made about any initial observations and ideas about the topics that the participants had discussed. An example is presented in Table 8, below.

Table 10. Example of the familiarisation process

Transcript	Initial Impression

Liwei -I think the one thing I would like to improve in Malaysia, is about confidentiality, that's very, very poor. There is no confidentiality at all. For example, in a clinic in a small clinic, because there are too many patients waiting outside, so in one clinic there will be 3 doctors seeing 3 patients simultaneously. So, there is no confidentiality at all. So it's like this room (pointing to the office we were in), and there's three doctors sitting here, here and there and then there's 3 patients	The participant talks about wanting to improve confidentiality, the setting diminishes confidentiality or negates confidentiality. He also speaks about the number of patients and doctors, the size of the clinic and the close proximity of patients.

Generating open codes - delineating units of general meaning

A line-by-line analysis followed, questioning "What *is the text saying?*" and "*What is the text telling us?*" This gave a very detailed analysis of the transcripts. The example below demonstrates line-by-line analysis of an extract. In this analysis, questions were also noted around the text, as the researcher also considered the importance of what was not being said, just as much as what was verbally expressed.

Table 11. Example of open coding

Transcripts	Open Codes
Liwei -I think the one thing I would like to improve in Malaysia, is about confidentiality, that's very, very poor. There is no confidentiality at all. For example in a clinic, in a small clinic, because there are too many patients waiting outside, so in one clinic there will be 3 doctors seeing 3 patients simultaneously. So there is no confidentiality at all. So its like this room (pointing to the office we were in), and there's three doctors sitting here, here and there and then there's 3 patients	Poor confidentiality Wanting to improve confidentiality Too many patients (patient numbers) Staffing numbers Size of clinic Close proximity of patients being seen Simultaneous consultations in a small space Lack of confidentiality

Lutfi -but even in clinics, patients are next to each other in primary care. I was helping the doctor in clinic. It is like primary care but it's done by the doctors not GPs. There are two tables attached to each other and the patients are sitting with backs facing each other, and they could actually… and there was only one examination couch with a curtain so patient came in and I needed to do a PR exam(…)Then the next thing was a lady with a chest problem and the patient is willing to.. you know.. to like take off her clothes to do a proper examination of the chest and again there is a male patient in the same room, and I was like "ok then, what shall we do next!" And again the doctor said "just use the couch there, there are no other couches."	Close proximity of patients Patients seeing each other Lack of resources/equipment Performing intimate examinations Patient acceptance Patient willingness to expose themselves No gender separation Uncertainty about the appropriate action in this situation Lack of facilities and resources

Coding was carried out through the highlighting of keywords and phrases used by the participants. These general codes were refined into categories and themes. Further detail of each stage of the process is provided in the following sections. Numerous words and phrases were collated and reading through them collectively enabled the researcher to group these as units of general meaning or codes.

The transcripts were revisited to ensure all possible codes had been identified and that saturation had been achieved. These newly-defined codes were constantly compared with previously-identified codes to confirm if these were new codes or if they had been identified through the previous process.

To facilitate the handling of the data, all quotes identified under each code were copied and pasted into a document (Appendix E). This generated a number of documents each with data related to each generic code. This gave the researcher an opportunity to view the type and amount of data generated under each code and demonstrated that some aspects of the interviews could be classed within several codes. The process of data reduction is very much a part of the explication process, and the researcher needs to make decisions as to which data to select from the larger data set (Namey et al. 2007). From this, it was easier to assess if the data collected under these codes related to the research question. This strategy is supported by Gibbs (2007), who states that it allows quick collection of all the text coded, thus allowing the researcher to read through and see what is at the core of the code (Gibbs 2007).

Categorising codes

Data within the codes were re-read, and data of similar meaning were clustered together and refined as units of meaning to create categories. This is depicted in Table 10, below.

Table 12. Development of categories from codes

Open Code	Category
Poor confidentiality Wanting to improve confidentiality Lack of confidentiality	Practices compromising confidentiality Attitudes towards confidentiality
Lack of facilities and resources Staffing Clinic size Patient numbers Simultaneous consultations	Clinical environment and impact on privacy/confidentiality Risk of accidental disclosure of patient information to other patients
Close proximity of patients Performance of intimate examinations Patients seeing each other No gender separation	Lack of privacy Risk of exposure to others Patient vulnerability Lack of dignity
Patient acceptance of care Patient willingness to expose	Issues of patient consent to care Trust in the doctors

This process was carried out for each interview with numerous codes and categories being generated from this process. These categories were related to the aims and objectives of the research, and redundant codes were eliminated.

Thematic development

A theme is defined as an important aspect taken from the data in relation to the research question and represents some level of patterned response or meaning within the data set (Braun & Clarke 2006). Themes were generated from the categorising of the open codes, providing information about the participants and their experiences, as well as addressing the aims of the research.

Identifying themes from the codes

The data were revisited with the purpose of identifying and clustering categories of relevant meaning together in order to define a theme. The process depicted in the above tables was conducted across the entire data set. From Table 10, it can be seen how categories were defined. Table 11 (below) offers an example of how themes were identified from the categories.

Table 13. Themes identified from categories

Category	Theme
Clinical environment and impact on confidentiality Practices compromising confidentiality Attitudes towards confidentiality Risk of accidental disclosure of information	Confidentiality
Lack of privacy Risk of exposure to others	Privacy
Lack of dignity Vulnerability	Dignity
Issues of patient consent to care Patient trust	Consent

The reading of preceding statements captures the essence of the discussion and offers an appropriate interpretation (Tesch 1990), which is an important factor within the presentation of findings. To offer the reader an accurate representation of the context of the discussion, chunks of data are presented in order to clearly illustrate what is being conveyed by the data.

The themes were reviewed to ensure that there was resonance with the coded data and that they presented a compelling and convincing story about the data (Braun & Clarke 2013). Maguire & Delahunt (2017, p. 3358) offer a set of questions to aid the process of reviewing and refining themes, as discussed below.

Do the themes make sense?

Appropriate "labelling" of themes is a key factor to capturing the essence of what is being conveyed and was achieved through reading and labelling, and re-reading and re-labelling, together with discussion with the supervision team, until the researcher felt that the essence of the data was accurately captured by the title.

Does the data support the themes?

It is important for the researcher to stay close to the data and not to extrapolate beyond it. This question asks for consideration that the themes are identified and evidenced from the data, with enough data to support it (Nowell et al. 2017).

Am I trying to fit too much into a theme?

Interviews generate copious amounts of data. Themes need to be broad enough to capture the essence of what is reflected in the text, whilst being discrete and significant enough to enable the researcher to manage the amount of data as refined and succinct themes (Attride-Stirling 2001).

If themes overlap, are they really separate themes?

In Table 9, it can be seen how codes can be aligned with more than one category (lack of privacy/lack of dignity), and the same was true for categories overlapping to more than one theme, with privacy and dignity being examples of overlapping themes. In the examples above, the same data correlates to both of these themes. From a small selection of data it is difficult to convey this distinction, but is evident in the context of the wider data set. However, privacy and dignity are two separate aspects of the approach to the delivery of healthcare. Whilst privacy relates to a sense of being away from others and boundaries of the self, dignity is the concept of treating others with respect and being treated as a worthy individual. Thus, although data overlaps between the themes, there is enough evidence from the data to support these independently. To not separate these themes could make a theme too broad, as it does not clearly or succinctly reflect what the text is saying or what it is telling us.

The stages of contextualisation and presentation of the themes will be presented in the findings chapters. It is here that the themes are presented in alignment with the corresponding data, to create a compelling description of the participants' lived experiences, whilst addressing both the aims and objectives of the research and the interpretive process which led to the development of a model.

Ethical considerations

This research was conducted with human participants and thus required the consideration of key ethical issues that could arise from the research study.

Informed consent

A robust process of informed consent was undertaken within this study, where the researcher was an insider researcher (Costley 2010). The participants were provided with an information sheet outlining the aims of the study, their role as participants and what they could expect from participating. The voluntary nature of participation was emphasized, highlighting that there were no consequences if they chose not to

take part, and that they were free to take part and withdraw without giving a reason. It was explicitly explained that choosing to take part or deciding not to, or withdrawing later, would have no consequences on the outcome of their programme of academic study.

The researcher provided consent forms which reiterated participants' right to withdraw from the study at any time. The consent forms were signed and dated by the participants as a record of their agreement to take part. Details of those supervising the researcher were provided on the information sheet, should the participants feel the need to raise concerns about the study or the researcher. Participants were over the age of 18 and were considered to have capacity to volunteer to take part.

Confidentiality and data protection

An important feature of the interview process was the notion of providing the students with a safe space in which they could have their voices heard. As the interviewer, this was one of my roles and although this was easy in individual interviews, in a focus group this could have posed more of a challenge. In a focus group interview it is not possible to ensure all participants maintain confidentiality, as the participants interact with each other and hear each other's views and experiences. To address this issue, ground rules were set at the beginning of the focus group interview asking the participants not to discuss matters raised by other participants once outside of the focus group. The participants were informed that they were free to discuss any matters they felt were relevant, but were made aware that the interviewer had a professional responsibility to report issues of misconduct or patient safety, should these arise. The participants were aware prior to attending that the interview would be in a focus group format, had consented to take part and were therefore willing to share their thoughts and ideas with other participants. All participants were advised that they were free to leave the interview at any point without any impact on their studies.

Personal data was not used and all information provided by students during interviews was anonymised. This was achieved by not using the participants' names in the interviews or transcripts. Pseudonyms were used in order to anonymise the participants, and a record of the pseudonym of each participant was kept in a separate electronic file. No other details were included in the transcriptions that could identify the individuals. Data was stored on Northumbria University's U-drive, which is password protected. Hard copy transcripts and audio recordings (until such point as they were uploaded to e-format onto the University U-drive) were stored in a locked filing cabinet to which only the researcher had access. The information gathered was used solely for the purpose of the research and will be kept for approximately 8 years after the study in order to support writing up of the thesis and the development of journal articles and conference papers. It will not be kept longer than required. Data will be discarded in an appropriate manner at the end of this time period, as per Northumbria University Ethics and Governance Handbook (Northumbria University 2018).

The researcher was aware that these discussions could have raised sensitive or emotive issues, and that this could have caused distress for participants. In this instance, the discussions would have been suspended to ensure wellbeing of the participants. If more support was required, the participants would have been referred to the student support team within the department. Although this never occurred it was important that there was a mechanism in place should any emotive issues that warranted additional support have been raised. The participants were made aware that disclosure of sensitive issues could have highlighted professional misconduct, unsafe practice or criminal acts, which could have resulted in the matter being referred to the appropriate authority, or senior staff member, in line with Trust guidelines and code of professional conduct e.g. Nursing & Midwifery Council (2009). Therefore, in this instance, participants would have to understand that confidentiality would have to have been breached. This was made explicit in the participant documentation in order to support fully informed participation in the study, and can be found in Appendix C. No disclosures were made during the study.

Prior to commencement of the study ethical approval & permissions had to be gained (and are included in Appendix A) from:

Northumbria University
The UK University's medical school at which the participants were students
Research ethics committee
The local hospital trust's research & development department

These processes required exploration of various issues, such as:

Researcher position – as tutor within the department, and interviewing students from this department, there is a power differential, where it could be argued that the researcher as tutor has power over the participants. This power differential means that there was the potential for coercion of participants, particularly if the researcher was recruiting the participants in person. This was overcome by inviting the participants via email/letter and following the detailed process of informed consent as highlighted above. The information leaflet clearly set out the voluntary nature of participation and the fact that their decision whether to take part had no consequences on their programme of study. The information leaflets also included contact details of the PhD supervision team, so that potential participants could contact additional individuals for information about the study.

As University students at a local medical school, consent for approaching them was required from the university's medical school ethics committee.

Although the study did not involve patient participation, due to the fact that the research involved NHS students, the researcher was a worker of the NHS, and data were collected on NHS premises, the project was submitted for proportionate review to the local research ethics committee.

Due to the fact that the interviews were being conducted on trust property, approval was sought from the local NHS trust R&D department.

An up-to-date CRB check was conducted on the researcher as part of the ethical approval process.

Power relationships between the researcher and researched

The researcher discussed their position within the study, and their relationship to the participants, in the early chapters in this thesis. This included other aspects about them such as interest in the research topic and their profession. The researcher had to consider the impact of their position on the data collection to ensure that no prejudice existed in the invitation and selection of students for interview. The researcher therefore had to ensure that questions were not asked based on their knowledge of the participants individually, but were instead aligned with the methods and methodology discussed. Hence, an interview guide was utilised which ensured that all interviews allowed for discussion of the aspects aligned with the research aims and objectives, whilst also allowing for relevant digression and flexibility. In so doing, there was no abuse of the tutor-student relationship.

The researcher had to consider the impact their position within the department and relationship with the student participants could have on the quality of the data collected. Therefore, the researcher clarified to all participants that their participation would not affect the outcome of their studies, with the aim of eliciting open and honest responses from the participants. However, at the point of interview, the researcher did not have an influence over the students' assessment performance, and thus this minimised the potential for conflicts of interests between the researcher and the participants.

Summary

This chapter presented the research methods, the rationale for using these, and consistency with the research methodology. There has been a brief description of

the sample population, but in the following chapter there will be more in-depth description of members of this population in order to provide perspective and context.

Within this chapter, sampling, recruitment, data collection and the analytical tools utilised in the study have been presented and critically evaluated. Strengths and limitations of the selected methods were explored, providing evidence to support the suitability of these methods in this study. This chapter has illustrated how the chosen methods align with the adopted methodology and presented a rationale as to why qualitative research methods are optimal in answering the research question.

The following chapter presents the findings of the process discussed here. It will provide interpretation and analysis of the codes and themes that have emerged from the raw data. From this analysis, the researcher will aim to draw out information that will answer the research question: "*How Malaysian medical students on a partner medical school programme develop an understanding of the ethical dimensions of practice.*"

Chapter 5

Partner medical students' awareness and understanding of the ethical dimensions of practice

Introduction

The participants engaged in rich discussions about the clinical placements that they had completed in Malaysia and the UK during their partner medical school programme. They had opportunities to visit different clinical areas, observe assessment and treatment of patients, and to develop their own clinical competencies. Within their discussions about clinical practice they considered situations where ethical issues should be considered; ethical ideology, where they explored the morality of actions and the consequences of those actions; and their views about how they should fulfil their duty to their patients. Their awareness of these subtle yet critical issues prompted these medical students to consider the rightness of actions and reflect on the appropriateness of alternative approaches to patient care. Throughout this chapter the participants' journey in their consideration of the ethical dimensions of practice is presented.

This chapter commences with an overview of the participants' clinical experiences of their PMSP. This is followed by an exploration of their perceptions of the ethical dimensions of healthcare practice and service provision. Their understanding of ethical and moral principles that apply to the practice of clinical medicine is also examined.

Observation of clinical practice

During the PMSP, the students observed and experienced interactions between doctors and patients, students and doctors, and students and patients, in both public and privately-funded healthcare settings in Malaysia and the UK. The initial clinical placements were often short, lasting half to a full day, with three weeks being the longest placement. The transition from pre-clinical to clinical years (years 3-5)

coincided with the PMSP being delivered in the UK. The duration of the clinical placements increased at this stage of the course and could be up to 12 weeks. Throughout the programme, clinical practice placements were undertaken in different healthcare specialties, as described by Alwi:

> *Alwi - During mind and movement module MSK and CNS systems, we were sent to the hospital where, it was a teaching hospital, for half a day. We were taught history and examination on patients that they brought in from the wards. I had never been on the wards. Apart from a 3 week program, an elective, where you find your own special, specialist who will want to take you under their wing. So it's a three week thing. So you find yourself, and you apply. I did it with a paediatrician, and then you have another 2 weeks of general where you have to go to a GP. So it's 3 weeks specialised and 2 weeks of GP and then 2 days one of MSK and one of CNS. Hmm I think that's all… Oh we had 2 or 3 days in hospital as well. A special hospital for aboriginal people.. the people that live in forests. We went there for 3 days to this hospital. They have a helicopter service and they keep in touch with the leader of the tribes, so that's how they communicate. They have a satellite. It could be even more advanced than ours…… so that's how they keep in touch, how they communicate.*

In addition to being immersed in different medical specialities the students had the opportunity to complete practice placements in the same speciality in Malaysia and the UK. Here, Sarayah describes her experiences of obstetrics in two settings:

> *Sarayah - …it's a room, and the ward is attached to the room and the room has beds.. so the mothers will be wheeled to the room to give birth…..So we (the students) were brought to the labour unit for half a day. We were brought in through a door that goes straight through to the labour room, with many women giving birth, and there were no curtains…..And when I came here (UK placement) and I was on labour week, I saw the women get their own room with a bath tub, and some can even have a water birth, so I thought "This is very different" (to a previous experience of maternity care in Malaysia). It was a big change.*

In this extract, Sarayah made several observations. She spoke of the different environments where women were cared for during labour. In this description she drew attention to situations where patients could see each other as a consequence of a lack of curtains. Thus, the environment minimised the privacy that individuals could experience during labour. This was further exacerbated by exposure to medical students who were not involved in the care of these women when they walked through the labour room to observe in order to gain knowledge. She then

reflected on different practices she had witnessed where women were being supported with different approaches to birthing. There is an indication here that women were offered choice for the birthing process and supported to execute their choice through access to different care practices in specifically-resourced environments.

Sarayah indicated that there were many patients requiring care. Other participants also observed that clinical practice was demanding:

> *Alwi - I understand that they've (doctors) got quite busy worlds, but they don't have a really, good patient contact. So, they just look at the notes, all this is ok, we probably see you in a couple of weeks, your results are fine, just continue with the medication They don't say, "Is everything alright at home? How are you getting on with the business?"*

Alwi commented on the "busy worlds" that exist in healthcare and how this affects the quantity and quality of interaction between doctors and patients. His description portrayed doctors' approaches to patients as task-orientated and disease-focused. There was little attention to other issues such as how they are managing at home. Alwi's comment suggested that the task-orientated approach is influenced by the situation where the doctors work, where time spent with patients is restricted. Working in this way ensured that many patients received treatment, yet Alwi was concerned about how this affected the interaction between patients and doctors. Another participant suggested that a task-orientated approach to patient care was derived from the core aim of medical practice:

> *Jia - I don't think they really see patients as patients, but maybe more like a disease. But I guess in the end they still want to get the disease, they want to cure the disease, but slightly in a different way. Probably not in a nice way, but they get there, but in a different way and things like that. I guess it's the normal in Malaysia.*

Here Jia argued that the doctors' motivation is to cure disease. From this ideological stance the purpose of doctor-patient interaction is to assess, diagnose and treat disease and illness. Other participants, such as Lutfi, had different views of medical practice. He spoke of the importance of treating an individual and adopting a holistic approach to practice:

> *Lutfi - it's a complex thing, to have the "soft" skills, the skills around it, with the knowledge of medicine, "Give this medication, go home...". But because you are treating a human, it's not as straightforward as that, and when you talk to them, its not as simple as that.*

Lutfi's perception of doctor-patient interaction was complex and he suggested that there is a need to consider more than the presenting symptoms and treatment options. As an aspiring medical practitioner, he acknowledged the importance of gaining knowledge and developing competencies to treat patients. Yet he discussed the importance of considering an individual as a human, and the importance of dialogue with the individual to ascertain their wishes and preferences in relation to healthcare decisions. This discussion gives insight to the values that underpinned his clinical practice and the moral principles that he applied to his interaction with patients.

Similar to Lutfi, all of the participants presented descriptions of their observations of clinical practice that concerned how patients were treated by practitioners. Like Sarayah, Eu-Meh described the lack of privacy that some women experienced when giving birth, yet in other situations women were cared for in private rooms and offered a choice of birthing options. Alwi discussed the healthcare provision for aborigines in the jungle that enabled these individuals to access services that were tailored to the needs of this sector of the Malaysian population. Alwi and Jia spoke of the demands on healthcare services and how the greater good was served through approaches that enable practitioners to meet those demands. These discussions indicated that these medical students were aware of ethical issues that are inherent in medical practice from their initial clinical placements. As they progressed through their educational programme they completed clinical placements where they experienced different approaches to the delivery of healthcare, and this influenced their understanding of morally-correct or morally-condemnable actions. The participants frequently discussed what they considered to be their obligations and duties in relation to specific issues: informed consent, confidentiality, privacy, dignity, respect and to do good on behalf of their patients. These issues are considered below.

Upholding patient autonomy through informed consent

Consent was a topic that was discussed by the participants in all of the interviews. These discussions explored how they gained consent for taking a medical history, and more intimate and complex procedures. The latter included the process of obtaining informed consent for surgical procedures, and investigations such as chest auscultation and rectal examination. They also explored issues relating to practitioner, patient, communal and cultural attitudes and approaches towards consent. Nadia commented:

> *Nadia - …you are free to attach yourself to any ward, and you can get away with things like not introducing yourself. You can just basically walk up to a patient and just say, "Hi I'm a medical student, is it ok if we just, like, examine you?" and then you just proceed with what you are there to do. I guess that language there is a real barrier. I didn't do that because language for me is a barrier, because I left [Malaysia] quite early as well. But from what I can see, you can pretty much get away with many things like that. And obviously confidentiality, consent, comes in. It's a big role in the UK but it's not so much in Malaysia. I have seen doctors consenting patients, without like, to me, without even explaining properly to the patient what the procedure involves, what are the risks. I mean the patient might well die on the table, things like that. It needs to be discussed with the patient.*

Here Nadia mentioned the way that she introduces herself to a patient before proceeding with an examination. Nadia did not clarify whether the patient agreed to the examination when she states, "you just proceed with what you are there to do." Thus, it was not known whether the purpose of this interaction was clear to the patient. In doctor-patient encounters, agreement for treatment is often implicit and follows on from the individual presenting themselves in hospital, which is an indication of their willingness to receive treatment. Furthermore, the patient's engagement in the interaction and lack of resistance was additional evidence that they agreed to participate in their interaction with medical students. However, when medical students are in clinical areas they are there in a learning capacity, and not as qualified staff. This distinction may be unclear to patients, who may view them as doctors. This can place patients in a vulnerable position and undermine their right to informed consent. This example raises questions with regard to obtaining consent, as well as questioning the patient's understanding of the purpose of their interaction

with the students. However, in their aim of completing the task set for them, students can focus on patients being a means to an end. The phrase "you just proceed with what you are there to do" implies that patients can be viewed as educational resources to achieve learning outcomes. In the following example Jia described her interaction with patients for learning purposes:

> *Jia - For us when we were doing pre-clinical years they put more emphasis on… like the patient is just something for you to do the exam on and you don't talk to the patient, it's like, "Hi I am just going to do this exam".*

What is noticeable about Jia's comment is the reference to the patient as "something" and not "someone." This depersonalizes a patient as an inanimate object that can be used for the purposes of learning. In Nadia's extract, she argued that she has observed different approaches to obtaining consent and indicated that it is important for patients to understand risks associated with treatment and the possibility that death might occur. Nadia argued that the patient has a right to make a decision about their treatment, and they need information to make an informed choice. Alwi acknowledged this also, however he suggested that information can be provided to the patient in a manner that encourages them to agree with the doctor's recommendation. Hence it is feasible for patients to be coerced during consent processes:

> *Alwi - everything (in the UK) is consented. But back in Malaysia, I don't have very much experience because I've not had any procedures done to me, and none of my family have done so, so I am not really sure, but I can make guess. Apparently, in hospital you can have consent but they (the doctors) try to give the patient the idea that you have to do that (have a procedure done).*

Alwi also explored the idea that doctors have well-developed biomedical knowledge and that patients should follow their advice:

> *Alwi - the doctor knows best about the disease and how to treat it. You (the patient) should take their advice.*

Inherent in this suggestion is the idea that patients require more than information to make an informed decision. Patients require information and they need to understand what is being asked of them and what they are consenting to. The patient requires information as to why they require treatment, what the treatment or procedure entails, and also to have an understanding of the risks associated with procedures and treatment options. They need this information to enable them to make an informed choice about whether to accept or decline treatment.

The influence of language on informed consent

In addition to discussing what information patients require to make informed decisions about their healthcare, the participants also argued that language could be a barrier to exploring treatment options and the risks associated with treatment with patients. Nadia, for example, described her junior education where she had been taught in English. As a medical student she had difficulty in communicating with patients in Malay or Chinese.

> *Nadia - I guess that language there is a real barrier. I didn't do that (approach and examine the patient) because language for me is a barrier, because I left the place quite early as well.*

Nadia spoke of the difficulties that she experienced in clinical practice and her awareness that she could not examine the patient without first gaining informed consent for the procedure. Nadia was interviewed in her final year of medical school and she recounted this experience from her first-year clinical placements. This suggested that she had an awareness and understanding of informed consent at an early stage of her medical degree programme.

Whilst Nadia described the limitations of her interaction with patients, Lutfi shared his experience of patients who were unable to communicate in the country's language and the impact that this had on obtaining consent.

> *Lutfi - I needed to do a PR exam, so I was "ok" but errmm I looked, we had a communication problem because she was from Vietnam so we tried to*

> *explain as much as we can that we needed to do a PR exam, and if they (the patient) were happy for me to do it.*

Lutfi described the challenge he faced when he was unable to converse with a patient in their own language when he needed to explain a procedure to a patient in order to obtain informed consent. Lutfi did not feel it was appropriate to conduct the procedure without the patient having an understanding of the process and giving their consent. However, Lutfi stated that the doctors tried as much as they could to give the patient an explanation and further stresses that this was a procedure that they needed to do, therefore indicating the necessity of conducting the examination. Despite language barriers attempts were still made to communicate with the patient. In contrast Hai suggested that efforts to overcome language barriers were not always made:

> *Hai - Multi–language can be quite hard when you are speaking to the patients. And we don't have much in interpreter so we often give up.*

Hai's phrase "we often give up" has serious implications in practice because a patient may not receive treatment due to a lack of understanding of what is being discussed with them in order to provide informed consent to treatment. Conversely, Hai also indicated that the patient may receive treatment without being fully informed. In both instances, the patients' right to make decisions about healthcare and treatment are impaired. However, stating that they don't have "much in interpreter" implies that the inability to communicate with patients is dependent on the available resources. Therefore, the clinician's approach to upholding the patients' rights to informed consent is reliant on constraints such as lack of resources within a clinical area. This is not necessarily indicative of the clinician's own philosophy of practice.

Hai drew a comparison by sharing an experience of overcoming language barriers to communicate with patients whilst on placement in the UK:

> *Hai - I see them in GP, I even talked to a patient that was deaf. But at least here if they don't speak English, they have a relative with them. Although the rules (in the UK) say that you shouldn't use a close relative, but they understand that if you have an interpreter available, like they*

have telephone interpreters, which I think is quite useful. I have seen some consultants do that. Although it's quite annoying to pass the phone around but at least you have the opportunity to talk to the patient.

Hai described the systems in the UK that support doctors and patients to communicate with each other. His final sentence captures his understanding of the importance of these systems in supporting doctors to talk to a patient and, in so doing, enabling the patient to receive information about their health conditions and associated treatment. Hai noted that in the UK "the rules say that you shouldn't use a close relative", thus highlighting the different roles that family can fulfil in the UK and Malaysia. These examples show the very different practice experiences of these participants. Yet, they emphasised their understanding of the need for informed consent through providing information and overcoming communication barriers. They identified the importance of being able to talk with patients in a language that they understand in order to convey information about their treatment and conditions.

Alternative approaches to care delivery and obtaining consent

The participants were aware that consent could be verbal, written or implied. Consent is implicit when a patient acts in a manner that indicates acceptance or there is a lack of action to indicate refusal of care. The participants identified instances in clinical practice where verbal consent from the patients could not be obtained, yet healthcare workers continued to deliver care. Nadia described this when healthcare workers were deployed to remote areas to provide access to care to the inhabitants of a remote village. When recalling her visit to a hospital for indigenous aborigines of Malaysia, she stated:

> *Nadia - …it is a community hospital dedicated to people who are of that descent. You must be an Aborigine to be able to go there. Like a special right sort of thing, like similar to the Aborigines in Australia, they have special rights, so they go to the special hospital. Actually, they don't go, it's more like the government sends health professionals in there to like… care for them and to look out if they have any serious things or whatever and bring them back.*

Nadia's observation highlighted circumstances in which consent is not always prioritised. She talked about staff "caring" for the tribespeople, and this indicates that

these health workers acted paternalistically when accepting responsibility for the welfare of these people. In addition, in the following extract Nadia indicated a regard for the health of the wider population through the management of "TB and other infectious diseases." The concern raised by Nadia in this situation was the importance of acting for the greater good and balancing this with the needs of individual patients:

> *Nadia - … some of them don't even know why they are there. They don't want to come out of the village, the village is remote, like, in the jungle with no… So then, it's different. Even like, we were told to examine some of the patients there, who were like, had TB or had other infectious diseases, and then, you didn't need to seek any consent or (laughs).. I don't know.*

When talking about the aborigines in the hospital Nadia stated that "some of them don't even know why they are there", suggesting that these individuals lack knowledge or understanding, or that they may not have been fully informed of the reason they were asked to attend the clinic. Nadia speaks about the tribespeople not wanting to come out of the village and how they preferred to keep their distance from other populations. Therefore, they would not seek access to healthcare services. In this situation the tribespeople were not resistant to receiving care, hence their consent was implied by their actions:

> *Sarayah - …that's because they (the aborigines) don't live near, they live in the forest. So they don't go to the main city where the hospitals are. So, we have very near the hospital, and the forest, for them. So, then the staff would go once a month or every two months into the forest to look for them and help them.*

Sarayah also commented about medical staff seeking out the tribespeople and bringing healthcare to them. In their observations, Nadia and Sarayah depicted health service personnel as caring and helpful, particularly in assuming responsibility for the tribespeople and acting in their best interests. They have presented an argument that there are conflicting principles and they described a situation whereby health professionals act in the patients' best interests, thus the prima facia duty of the doctors to do good (beneficence) overrides the duty to maintain patient autonomy. Ibrah provided insight into how the tribespeople were contacted and how care was arranged for them:

> *Ibrah - …they have their own healthcare system. I've been doing some work with Aborigine people in Malaysia. They, they live in quite a remote area in the jungle. So the hospital in Malaysia they have a helicopter service and they keep in touch with the leader of the tribes…..They have a satellite, it could be more advanced than ours. That's how they keep in touch, how they communicate.*

Ibrah spoke of how the healthcare staff liaised with the leader of the tribespeople, and information was relayed to the tribespeople via their leader. Ibrah indicated that regular communication takes place between the healthcare providers and the tribe's leader. The role of the leader was not elaborated on in the interview, but this extract suggests that they are a key figure in being an intermediary between the tribespeople and the healthcare workers. This approach ensured that language barriers were overcome:

> *Nadia - So these were the Aborigine in Malaysia. So then we went there, they don't speak Malay, so they speak in their own language as well.*

The health professionals in this scenario upheld the tribespeoples' right to access healthcare whilst respecting their wishes to remain on the margins of mainstream society. The leader was an intermediary figure who fulfilled the role of advocate for the tribespeople, ensuring that they were informed by providing information about healthcare services in their own language. The outcome was that the tribespeople had access to healthcare that was tailored to their needs. Otherwise they would have been restricted if they were required to attend a larger inner-city facility, which Ibrah described as being "daunting" for them. Accounting for the diverse nature of this population resonates with respecting individuality and patient choices, as they offer accessible services that have a good fit with the cultural norms of this population.

Making decisions about care – approaches to enabling patient choice

Providing accurate information was highlighted by Nadia and Hai as key factors in empowering patients to make informed decisions about their care. However, Nadia, Ibrah and Sarayah also described their observations of situations where patient choice was diminished, and professionals acted in the patients' best interests.

The participants observed the varying circumstances and processes by which patient choices were made and executed. In some clinical environments, patient choice was executed following the individual making an autonomous decision. In other situations the family assumed an active role in the decision-making process. Whereas, in other clinical situations, practitioners led the decision-making process.

> *Alwi - …in here (UK) ideally it's up to the patients to decide, if they have as much capacity, and then I can see that the patients can refuse treatment and the doctors are perfectly fine with that.*

Alwi observed how patients were able to make decisions about their care and have their rights to decline treatment upheld. Alwi did however make a point of noting patient capacity in order to be able to exercise this right. Ibrah also observed instances where decisions were not always "doctor-led." Ibrah described her experience of end-of-life care, where she talked about the family, and not doctors, making decisions about the patient's care:

> *Ibrah - …it depends on the patients' background and ethnic group, because they have different approach. So, I think, I have personal experience of this. My great-grandmother had cancer, so the family decide to stop the treatment, and she agreed with that. And then they brought her home, so she spent her last few months at home.*

Ibrah argued that the approach to decision-making is dependent on cultural issues. It is significant that Ibrah stated "the family decide to stop the treatment, and she agreed with that." Whereas previously Sarayah and Nadia had indicated that health professionals actively made decisions for their patients, here, Ibrah stated that the family were making decisions on the patient's behalf. Yet the patient was still involved in the process as she confirms that the patient agreed with this decision. Thus, Ibrah described her great-grandmother as an autonomous adult, who made an informed choice to allow others to make decisions in her best interests. Although this differs to the patient making decisions directly with doctors, it is still indeed a valid choice and an expression of individual autonomy.

Ibrah described a situation whereby the family led the decision-making process but specified that the patient agreed with this decision. What is difficult to ascertain from this extract is if the patient had made an advanced decision for the family to ensure her wishes were fulfilled, or if the family took charge of making decisions without direction being set by the patient. However, it is still clear that the patient agreed with the decision that was made, and she was able to express her preferences. Ibrah described the patient's relatives as advocates, ensuring that the patient's wishes were upheld. She highlighted a distinction between making a decision and executing a decision. Patients actively deciding for others to consent on their behalf remains an autonomous act.

The role of the family in patient choice and decision-making

The participants spoke of the family as playing a significant role in the patient's interactions with healthcare professionals, including their decision-making processes, treatment options and longer-term care. There are significant variations between cultures in the roles that families fulfil. The participants suggested that in Malaysia, holistic care incorporates the inclusion of the family, and thus the focus in healthcare situations is not just on the patient. Whilst in the UK, they observed how family involvement was often dependent on the wishes of the patient. However, within both settings, the involvement of the family in care and decision-making was a key feature. Naseem provided a specific example of the family taking an active part in decisions regarding care:

> Naseem - …but issues like abortion, it's not just about the patient but all the family. So, it's not just a decision made between you and the doctor, but with the father and mother as well. Things like that. It's part of society, part of the culture.

In this extract, the patient's parents were involved in making complex and sensitive decisions with the young person. Alwi considered care for older people in the community and he described what is expected of the family:

> *Alwi - …because in Malaysia, I mean, I don't know, if you have elderly patient who is quite old, if they think that this patient is fit to discharge, they just discharge, social care depends on the relatives. There has to be a relative there, if there is none they put them in a well house or somewhere like that. But I mean but for the majority there have to be children there for their mum or their dad, there are no issues of social care or things like that or complete social care, which I see is quite, quite an issue here (UK).*

Alwi highlighted the availability of services in different countries and cultural expectations regarding provision of care. There is an expectation in Malaysia that the family will care for older and/or disabled relatives, as a continuation of hospital care, upon discharge. Nadia had commented on how good discharge planning and social care was in the UK, and the active role that nurses take in supporting patients:

> *Nadia - I think the nursing staff here take quite an active role especially in terms of arranging the social bits… the main things like discharge planning. I think the nurses take an active role in the social bits. Like let's say a patient cannot cope at home, then they would bring it up to the doctor and alert them and make further arrangements, like whatever…rehabilitation or social services input, quite a lot of things, and benefits. Sometimes they get involved in that whole circle, and I think that's really good. I don't think people in Malaysia do that, and I don't think the nurses in Malaysia even know how to do that.*

Nadia's remarks illustrated the differences between nurses' roles in Malaysia and the UK. Yet, the difference observed by Nadia is due to the active role that the family (in Malaysia) assume in caring for their relatives. Thus, the need to arrange care for patients in the community is not as prevalent as it is in the UK. These discussions suggested that the family made a significant contribution to patient care in the Malaysian setting. The focus of care is as a family unit and not simply as centred on one person, i.e. the patient, with the family acting as an advocate for the patient, having information shared with them freely and being involved in the decision-making process. It is an important influence on how the students develop their understanding of ethical dimensions, as they find themselves harmonising two sets of ideals. One which advocates a person-centric approach with a focus on the autonomy of the individual (patient), and an alternative perspective in which holistic

care refers to the whole family and not simply the patient as a whole. Nadia and Alwi noted that in the UK, nurses and allied health professionals play a part in providing the care that in Malaysia would normally be undertaken by the family, and were respectful of the role that these professionals had. Saying this, however, the participants are perhaps drawn to issues where, in their experience in the NHS, there exists a choice of care for patients and their families in the community, and thus it is not assumed that care will be provided by the family.

Cheng provided an example from his observations of a consultant in the UK interacting with a patient and their family, and he drew attention to the importance of communicating with and engaging the family:

> *Cheng - I recently did a placement with Dr H at C Hospital. Yeah, he's a very nice guy. He took time to talk to the patients, to talk to the family. He really used the SPIKES* things if you want to break bad news to the patient or the family, yeah.*
>
> *Researcher - So how important do you think it is to communicate well with your patient?*
>
> *Cheng - …it is very important (laughs)… especially their family. Because I think it's their family that sometimes cannot understand, and they need a little more time. Because some of the family are quite demanding, "Why are you not doing this? Why are you not doing that?" So, you need to take a little more time to explain to them.*

Cheng made a connection between the theoretical knowledge that he acquired through the taught element of his programme and the approach adopted by the doctor he observed in the above example, and he spoke of using SPIKES, a communication skills tool (**S**etting, **P**atient perspective, **I**nvitation, **K**nowledge, **E**mpathy, **S**trategy) utilised when engaging in difficult and emotive consultations with patients and their families. Cheng spoke about his observation of the doctor taking time when breaking bad news. He observed how the doctor adopted a compassionate approach whereby there was consideration of the needs of both the patient and the family. Cheng portrayed the family as advocates for the patient in their time of need.

Sarayah highlighted a similar situation in which the patient's choice and care are dependent on the family. However, in this scenario Sarayah presented how patient information was unintentionally disclosed without the patient's consent, when attempting to make shared decisions on the patient's behalf:

> *Sarayah - …the consultant had to speak to the family of this patient, who had just been admitted this morning with a stroke, and they were talking about the DNAR and the prognosis in the corridor in front of the mobile computers, you know, where they can show the scans. I was in the corridor, and there was people walking in and out, and people walking past, through them. But the consultant himself was very nice to the family, but I think the situation was very busy and there was a gathering of people… physiotherapists, nurses.*

The patient who was given a do not attempt resuscitation (DNAR) order was discussed in a corridor with what she described as numerous people walking past and through the group discussing the case. Sarayah described how the lack of facilities for staff and family to meet and engage in the decision-making process compromised the patient's privacy. Sarayah's example also highlighted the necessity of involvement of the multi-disciplinary team in order to provide the family with all the information they required to make decisions regarding the care of their relative. The need for sharing information overrode the need for a more appropriate environment. But Sarayah presented this not only as how confidential patient information is shared with the family in order to inform their decisions about patient care, but also how the lack of facilities compromised the confidentiality of this information. This example demonstrated how the patient's consent was undermined due to the gravity of the situation and that consent for family involvement is implicit. Having discussions in a public area of the ward results in others not involved in the patient's care overhearing these discussions, and thus information is unintentionally divulged to third parties without the patient's explicit consent. However, this is not to imply that the clinicians purposefully disregarded the patient's consent regarding discussions about their care; it was the necessity and urgency of the situation in addition to the lack of appropriate facilities that may have led to this breach.

The role of the family in healthcare decisions is complex. The participants showed that in the UK the family plays the role of advocate and carer, but also noted that wishes of the patients were given consideration with regards to sharing information with families as well as having them present in consultations. They spoke of the role of nurses and allied health professionals in offering care to older and disabled patients in the community, whereas this differed from their experiences in Malaysia. However, these observations do not simply show differences in the expectations of the responsibilities of the families in both countries, but also illustrated that in the UK there is choice for families and patients in how care is provided in the community, in partnership with health professionals.

Culture and beliefs - patient expectations and decision-making

Participants spoke about how religious and cultural beliefs influenced the way that doctors they had worked with behaved within their professional roles, and the expectations the patients had of care. The participants spoke of how they had observed the beliefs pertaining to the national religion of the country, as well as the patients' own religion, and how this had an impact on the way that care was delivered and the decisions were made.

Beliefs and impact on patient choice

The participants described how they observed the influence of the dominant religion in the country and how it impacted on the choices available for patients:

> *Nadia - The religion plays a big part in basically dictating how the country is run. Yeh that's it, it revolves around religion mainly. So, any arguments you can make, as long as it comes from the Quoran, then its fine.*

Nadia used the word "dictating", which denotes strict and rigid guides. She stated that in Malaysia the Quoran is used for running the country. Nadia suggested that

the national religion influences the governance of the country. Pei-Jing provided an example below:

> *Pei-Jing - …the difference is that abortion here is legal and that's when you have a valid reason like if you screen the baby and its Down's syndrome, you can choose to abort or not. In Malaysia, it's not so much of a medical issue, but a religion and cultural issue that is against abortion, that made it illegal.*

In the above, Pei-Jing's perception that abortion is legal in the UK if there is a valid reason is not wholly accurate. Her impression of the legal status of abortion may be due to an acceptance of abortion within a more secular society. However, the Abortion Act (1967) does not legalise abortion but prevents the prosecution of a person if a pregnancy is terminated under specific conditions, primarily if continuing with the pregnancy will:

cause significant harm to the mother

cause harm to the family

cause harm to unborn child through significant mental or physical abnormalities.

This suggests that medical practice is influenced by both culture and religion, but according to Eu-Meh and Pei-Jing this is not true of hospitals in the private sector in Malaysia where "illegal" abortions occur. However, in the UK, religious groups also play a part in opposing such legislation, and the Abortion Act (1967) specifies that clinicians involved in enabling a patient to have an abortion should be acting in "good faith." Pei-Jing spoke about abortion but failed to make a connection between the legalities of such procedures and inherent values in society, as law has its basis in long-established dominant values. What Pei-Jing is alluding to here is that, in the UK, the patient's right to choose is upheld without regard for their financial status, thus offering an equal right to care:

> *Eu-Meh - …in Malaysia there is Private and Government so private do their own stuff and Government do their own stuff. So even though Government have introduced guidelines, you know obligations to follow, but the private ones have their own way and abortion's one of them. A lot of well, affordable families they, if the government don't want to do abortions, for which they have to wait on a waiting list. They do have a waiting list for abortions.*

Eu-Meh raised the matter of obligation, which relates to the issue of duty. Eu-Meh demonstrated a disparity in the healthcare available to wealthier families and those of a lower socioeconomic background. Eu-Meh's point relates to the discussion of inequality in the provision of and access to health services. It illustrated that although there are treatment options for patients, the patients' ability and freedom to choose is influenced by factors such as affordability of treatment, thus infringing on their liberty. The comments above illustrate the participants' observations that guidelines based on belief systems may be overridden if a patient can afford to pay for the treatment, thus indicating that unfairness exists within the system, whereas they perceived the system in the UK supports equality through access to healthcare for all. In identifying these issues of inequality and unfairness, Eu-Meh was discussing the ethical principle of justice.

In the above, Eu-Meh stated that the public and private sector have "their own ways." Initially, Eu-Meh's statement appeared to be discussing the differences in the healthcare systems, implying that the private healthcare system disregards government guidelines. However, prior to Eu-Meh, Pei-Jing stated that "abortion is not so much of a medical issue, but a religious and cultural issue and also a legal issue…", suggesting that abortion is not a matter to be decided by the medical profession. Therefore Eu-Meh described the following of an alternative set of guidance for practice, which offers patients an alternative choice of treatment based on affordability and objectivity, not on religious doctrine. This was the participants' impression but it also demonstrated that the private sector is offering choice and treatment based on medicine and not limited by religious beliefs. Some remarks by these participants appeared disparaging about the private sector as disregarding the predominant religious beliefs of the country. However, the challenge here is that in the participants' descriptions, these choices in treatment are not available to all patients. The participants focused their discussion on the impact of religion. They did not discuss the impact of culture on the status of women in society in their ability to make choices on matters such as abortion, and if the process would differ if the patients affected were male.

Alwi provided an example in which he observed the depersonalisation of a patient by senior members of the team, raising that these issues of care pertained to the gender of the patient. He spoke of instances where he had observed the view of a female patient not being upheld, whilst in others he presented how there was consideration of the views of the female patient and presented the differences he observed in how women's choices were treated in two distinct settings:

> *Alwi - I mean in here (UK hospital) they (doctors) really, really ask… if the patient is a Muslim woman they ask if they want a male student or a male doctor in the room. They really, really ask. In Malaysia they wouldn't. I don't know, maybe it's changed now, but probably not… "Come" that's how they (the doctors in Malaysia) would say it. If there is a student, "Don't be shy" there's about 8 people in the labour room (in Malaysia).. .Our quality of care… if the end point is… recovery, then I would say probably the same (as the UK).*

Alwi's description portrayed this private event becoming a public spectacle. Alwi's statement presented the purpose of this patient's experience as an opportunity for students to observe as part of their learning but not contribute to the patient's care. This patient did not challenge this practice and the lack of control over how many students were present is implicit in this scenario. This experience had an impact on Alwi, as it challenged his beliefs about how to engage with a person and treat them with respect. He spoke of patients' rights being ignored and felt conflicted when beckoned by a senior member of the team to engage in this interaction.

Alwi was concerned about the patient's lack of involvement in the decision-making process about what happened during her labour. He drew a comparison between this situation and the practice he observed in the UK, where he emphasised that clinicians "really, really ask (the patient)". Alwi stressed that in one clinical environment the patient was consulted as to what their wishes are, and he stated this twice in his quote, denoting the importance of this. He also personalised his statement by stating "if the patient is a Muslim woman" as opposed to simply relating to the patient as "a woman." Alwi is a Muslim and indicated his awareness of the preferences of Muslim women to be treated (especially for intimate examinations) by a female doctor. Therefore, Alwi could identify with this and demonstrated empathy

with the situation from the patient's (or her husband's) perspective, in the disregard of their beliefs.

Patient beliefs and decision-making

The patients' expectations of the decision-making processes were influenced by their own personal beliefs and values. Alwi illustrated his experiences of the patients' involvement in the decision-making process and how these beliefs impacted on how decisions about care were made:

> *Alwi - People in my surrounding [as opposed to those living in main cities], they just accept it [the doctor's opinion]. So, they don't have to be like, involved in the decision-making process, they just accept it. Yes, that's it. Even myself, I accept what the doctor tells, it's not going to do any harm to me.*

Alwi revealed another factor which influenced the obtaining of consent alongside issues pertaining to decision-making. In previous accounts, doctors were portrayed as being central to discussions where information was provided for the patient to give their informed consent. However, in this account, the influence of the patient's beliefs and attitudes towards the medical profession were highlighted. Alwi discussed a personal experience where he highlighted the trust and respect he held for the doctor, accepting what he was told as it's "not going to do any harm."

Hai experienced two approaches to decision-making which reflected the complexities of a collaborative approach to care. He observed:

> *Hai - In Malaysia, the patient comes in and the doctor makes all the decisions and it's more of a doctor-centred thing. That's what I feel anyway. Most Asians when they see a doctor, it's the highest profession and they trust the doctor 100% what the doctor say is correct so they just follow what they say. Like here the patients argue with the doctors on opinions and things like that. In Asia, even though they will work things out together, they still trust a lot of the doctors, and follow like what the doctors ask them to do and take medication.*

Hai presents three different approaches to care. He spoke about the doctor taking a lead in making decisions, describing it as a "doctor-centred" approach. Initially, this

comment reflected a paternalistic approach, with the doctor assuming the role of carer. However, Hai described a high level of regard and trust in the profession, implying that patients are passive towards decisions about care and simply follow what the doctors advise. Yet, patients actively seeking information from doctors because of their level of knowledge and expertise implies an autonomous act in which they take responsibility for their health and seek care. The entrusting of their care to the doctor is in itself the patient's choice, and by willingly attending a health facility consent to care is implicit.

Hai also described a different experience in which there exists a dialogue between patients and the doctors as they try to "work things out together." Hai firstly spoke of patients and doctors working things out together, but stated that patients will ultimately follow the doctors' advice. This implies that after a discussion has taken place, the patient decides to act as per the doctor's recommendations and this decision is based on their trust for the profession and the doctor's level of knowledge. Guan-Yin stated that:

> *Guan-Yin - …people in Malaysia are not very well educated and they just trust what the doctor says. Here (UK) they (patients) will find out about the dosage and the drug and they keep taking the medication.*

Guan-Yin drew a distinction between the patients she encountered in both settings (UK and Malaysia). She demonstrated that patients she had met in the UK would independently seek information about their medication and thus the fact that they took responsibility for their own health was implicit. Guan-Yin's statement added evidence that these patients inform themselves about the treatments available and thus are in a position to have a discussion with their physician, as Hai had observed.

Some of Hai's observations depicted a sense of conflict between the doctor and the patient, as Hai spoke of "arguing" with doctors. For decision-making to take place there is a need for information to be shared between the doctor and their patient. Both parties need to express their preference for treatment and both need to agree on the choice of treatment plan. What Hai experienceed as arguing referred to the patient questioning and probing in order to gather information, as well as presenting

their own preferences. This does not confirm a heated conflict, but what Hai had found to be striking was the patient's ability to challenge or question the doctor. It could be said that this was considered disrespectful towards the doctor by Hai, hence his use of the word "argue." Yet, his account also depicted a scenario whereby there is a level of equality in the doctor-patient relationship, facilitating the interaction, discussion and agreement required to make shared decisions. Lian observed:

> *Lian - patients (in the UK) ask very relevant questions. However, in Malaysia patients don't question. Whatever you give, they will accept.*

Lian drew attention to the patients' questioning, implying that they want to have knowledge about their condition and treatment, and will therefore ask pertinent questions regarding their care. Whilst Lian described this questioning as "relevant," Hai's use of the term "argue" resonated with a heated discussion. His observation could relate to a discussion whereby differences of opinion exist between the patient and the doctor in finding common ground on which to focus and plan. A striking feature from Hai's discussion was the variances in how patient autonomy was expressed, whereby patients choose for doctors to make decisions on their behalf with or without discussion, and the extent to which patients were willing to challenge or express preferences for care.

The issue of patient culture was supported by other participants, such as Pei-Jing who stated that:

> *Pei-Jing - …it makes sense, explaining and gaining consent, is quite a good thing. It's just that in Malaysia, the patients don't have the same mind set (the expectation to be able to make their own decisions about the care they receive) as the patients here (UK). The patients in Malaysia don't care as long as you tell them what to do.*

Pei-Jing's comment subtly addressed some of the complexities associated with informed consent and decision-making. The latter extracts demonstrate an alternative stance to patient autonomy whereby patients make an autonomous

decision and trust the doctor to make important decisions about their care. Therefore, patients making informed choices to enable doctors to make decisions on their behalf is still a choice. However, this too raises the question as to what extent is this in itself an informed choice? The participants talked about the "mind set" and "accepting attitudes" of patients with regards to doctors. However, Pei-Jing presented a degree of conflict. She reflected on the fact that the practice of obtaining informed consent is good but alludes to the fact that due to the patients' mindset, there was no place for this practice in Malaysia. Her statement brought into question the transferability of her learning into alternative clinical environments in which the patients drive and influence practice. She described an environment in which the patients do not give importance to the receiving of information. Thus practitioners are not held to account by the patients, who are happy with being told what to do, questioning the purpose of this practice if it is not in the patients' expectations. However, in both examples, the participants reflected on how patient autonomy is exercised and how making autonomous decisions does not always look the same. Hai drew out the fact that although there is collaboration and explanation between the physician and the patient, the patient opts to follow the doctor's advice. Samyyah added to this in her description of her placements in Malaysia:

> *Samyyah - …the patients are not well educated, they all follow what the doctors say but they do have the choice to say "No".*

Samyyah portrayed that the patients in this setting do have autonomy and the ability to make choices, yet it is their autonomous choice to follow the doctors' advice. However, she spoke, as did other participants, of the patients not being well-educated. This lack of education and knowledge may impact on how empowered the patients feel about making decisions. Guan-Yin described the following situation:

> *Guan-Yin - …patients don't manage their conditions as they do here (UK). Some don't know what diabetes is. They just think, "I have to take this medication because I have diabetes." They come to the clinics, they get their bloods taken and the doctor adjusts the medications.*

Although Guan-Yin stated that the "patients don't manage their conditions", in view of suggestions that the patients are not well-educated, this may result in the patients not being able to manage their conditions if they are not knowledgeable on what their needs are. The participants stated that health promotion is not common in Malaysia (Sarayah and Alwi) and therefore patients are not aware of what they require for a healthy lifestyle and to enable them to make decisions about their own health.

The various comments the participants made suggest that doctors are highly regarded in Malaysian society. Alwi's view is of the doctors having specialist knowledge that should be respected. He stated that:

> *Alwi - …the doctor knows about the disease and how to treat it. You should take their advice. That's the way I've been brought up.*

Alwi showed that this respect for the doctor's level of biomedical knowledge and expertise has been passed down to him through his upbringing, alluding to the fact that this respect for doctors' knowledge is culturally integrated. Meanwhile, Hai stated (in his previous statement) that being a doctor is "the highest profession." Therefore, because of these attitudes, doctors may perceive themselves, or be perceived by others, as being in a position of power which can be utilised to coerce an individual to elicit a specific behaviour, and both can manifest themselves in various guises. Yet, although Hai and Jia have stressed their observation of this attitude in Malaysia, power issues are also commonplace in the UK. The participants did not emphasise that they had observed similar power issues in the UK.

So far, these discussions have portrayed that the patients' approach, whereby they allow doctors to make decisions for them, is based on the patients' beliefs and regard for the medical profession.

The use of language in a patient consultation can result in doctors interfering with their patients' autonomy and decision-making abilities. The structure of a consultation whereby topics may be avoided or emphasised could influence what

may appear to be the patient's choice. This was evident in Alwi's earlier comment that "the doctors give patients the idea that a procedure or treatment is required", and thus they encourage them to make a decision which the doctor thinks is the best course of action. In addition, power and coercion can be exercised through social institutions such as hospitals, which can result in patients becoming passive or subjugated. Institutional factors such as workload, which was discussed by Alwi and Cheng, exert a degree of power over a patient's ability to express their wishes by limiting the amount of time in a consultation. Nadia commented on how the doctors don't invite questions in busy clinics:

> *Nadia - …it's like 10 mins (for a consultation). And patients won't get the opportunity to ask questions, the doctor will be saying, "You have this, you have that, that is the treatment". It's like that… seriously…And the doctors don't invite questions as well. You know like here, after the consultation, they ask, "Oh do you have any questions for me. Have I been clear so far?". There's no room for that pretty much…*

This does not infer that the clinicians are deliberately exerting power over the patients, but this takes place as a result of the workload within the clinical environment, an issue which has been spoken about throughout the data. Arguably, what Alwi and Hai observed as being a "coercive" doctor-led consultation has its roots in their need to see a large number of patients in a finite amount of time, but is not an indication of the clinician's personal approach to care.

So far, experiences depicting professionals making decisions for patients have been presented. However, the participants did share experiences in which they had observed the promotion of shared decision-making and facilitation of patient choice. Ibrah also shared an experience from her placement in the UK, whereby she observed the process of shared decision-making between staff and a patient who was a Jehovah's Witness:

> *Ibrah –-…the only obvious things are with the Jehovah's Witnesses. They are the only exception. They don't even accept transfusion, if it's their own blood, even if it's running through. But I think it's been managed, it's great that we acknowledge their differences. We celebrate the differences. They're very accommodating, we listen to them and offer help in what they want and there is a lot of mutual understanding of what we can provide and*

what they want. And I really like to see that. It's a good thing, they're very accommodating.

She spoke of reaching a mutual understanding, signposting that staff and patients communicated with a view to finding commonalities on which to agree. This implied that differences of opinions may have occurred between what the patients wanted and what the doctors considered as appropriate courses of action. This example presented staff and patients working together to reach a compromise in care by respecting the patient's wishes in relation to the options available to them.

Within this section of this chapter, it has become evident that there are cultural norms associated with this area of clinical practice, from both a patient and professional perspective. There were observations of coercive practices from doctors which infringe the patients' rights to informed consent. However, other discussions within this section demonstrate a high regard for and trust in the medical profession, with patients making autonomous choices for doctors to act in their best interests, offering a challenge to the suggestion of coercion. Through reflection both in and on these experiences the participants developed their understanding of the nuances associated with consent, choice and decision-making. As they progressed through the partner programme their experiences varied considerably and this enabled them to continually develop and challenge their understanding of different approaches to informed consent and decision-making more generally.

Confidentiality

The participants spoke of issues of confidentiality when discussing the various aspects of patient care and clinical practice. They illustrated that confidentiality was influenced by various factors, including individual professional practices, legal requirements, limitations to confidentiality, professional guidelines, and environmental factors such as patient numbers. From exposure to these varied practices, the participants developed their knowledge and understanding of confidentiality and its implementation in practice.

Cultural perspectives and confidentiality

Culture has been identified as a factor influencing how the ethical dimensions of practice are implemented through professional practices and patients' personal beliefs and values. Naseem discussed confidentiality early in his interview, as he drew a comparison between his practice experiences in Malaysia and the UK:

> *Naseem - The difference probably when it comes to confidentiality that's what I think. Back in Malaysia this confidentiality… they still do confidentiality but maybe not as sensitive as here. So, some things, if you were in here, you would probably want to be careful when you talk to the parents. But in Malaysia if you are parents then for them its fine, is the same as talking to the patient, the parents have the same right to know as the patient, but probably not here. Here the patient has authority to control all the information.*

Naseem suggested that the way medics approach handling personal information and confidentiality in their clinical practice differs between Malaysian and British healthcare systems. Naseem speaks of his experiences in the UK in both adult and paediatric care whereby the patients' consent is required in order for their confidential information to be disclosed to others, including members of the family. He stated that "here (UK) the patient has the authority to control all the information." He drew on experiences in the paediatric setting in the British healthcare system, where considerations such as the patient's age, capacity (ability to retain and understand information), and safeguarding issues (where there is a need to disclose information to a third party if the patient is considered to be at risk of harm) are taken prior to discussing the patient with the parents. Whereas in a similar setting in Malaysia the participant suggested that the same considerations are not applied, and it is accepted that talking to a patient's parents is equivalent to talking to the patient themselves, an issue raised by other participants.

Pei-Jing presented a similar observation when completing practice placements in Malaysia, but within this she also raised the role of the family as a cultural aspect influencing the maintenance of confidentiality. She stated:

> *Pei-Jing - …the difference in culture is that in Malaysia it is more a of a family setting, that everyone shares everything, even with friends, so any medical conditions they would know. If my grandma were to go in, everyone would know what is happening. The doctor would ask my grandma, "Is it ok to show your relatives about what is going on?" It is an unsaid agreement that you can tell whoever.*

In Malaysia, it is an expectation of the patients and their relatives that information will be shared. Naseem and Pei-Jing addressed matters pertaining to family members of varying ages and roles, speaking about children, parents and grandparents. Issues between adults and children differ. With children there is a direct discussion with the parents unless otherwise indicated. However, Pei-Jing does state in the above example that the doctors address her grandmother directly with regards to sharing information with others. Although Pei-Jing alludes to the fact that patients would expect information to be shared, she still shows that patients are consulted with regards to whom their information is divulged.

Variation in approaches to confidentiality

According to the participants, there existed a marked difference in the maintaining of confidentiality across various clinical environments. Sarayah described the distinction between the private and public sectors, when she recalled her first experience of situations relating to confidentiality whilst on a placement in private healthcare service in Malaysia:

> *Sarayah - …when I was doing this elective paediatric placement in Malaysia, it was a private hospital, and the doctor told me about confidentiality. He told me, "Whatever you see here you cannot tell anyone!" and that time we weren't really taught about confidentiality, but he taught that to me, "You are not supposed to tell whatever you see in my clinic.".*

This description depicted what appears to be a very rigid approach to confidentiality. Sarayah quoted the consultant as saying, "Whatever you see here you cannot tell anyone! You are not supposed to tell whatever you see in my clinic." Such statements are open to various interpretations. One interpretation is the consultant is ensuring that areas of his practice are not divulged to others. Sarayah argues that this consultant is striving to protect the confidentiality of his patients. However, he does not solely specify the protection of patient information and Sarayah uses the words "Whatever you see", thus implying that maintaining confidentiality extended to more than just patient information, but other observed activities. The phrase, "You cannot tell anyone!", covers a wide range of individuals with whom patient encounters should not be discussed. Sarayah interpreted this as not sharing the information with others outside of the clinical area, including her family, friends and other students, as in the following statement she speaks about not being able to "share her experience":

The issue of confidentiality at this point was unclear to Sarayah as she had not been taught about how to handle patient information. Sarayah elaborated further on her interpretation of this experience, as it was her first encounter with someone who promoted this approach to patient care so avidly. Considering that at this point in her medical education Sarayah was a novice with little experience of clinical practice, she found herself confronted by very complex circumstances. In her following statement she discussed how she learnt that confidentiality is not and does not always have to be absolute:

> *Sarayah - At the time I thought I was not supposed to say ANYTHING AT ALL. So how could I share my experience? But then I learnt about not sharing the names, but I would go home and just keep quiet. – I can't say anything. Now I realise I can. But that was the first time anyone had told me what was confidential.*

Sarayah demonstrated how she developed her understanding of the concept of confidentiality. This first experience of confidentiality led Sarayah to adopt a literal interpretation of not sharing any information and refraining from discussing any experiences. However, Sarayah demonstrated how her understanding of confidentiality progressed as she learnt about "not sharing the names", and thus anonymising cases when discussing with others. The phrase *"Now I realise I can"*

within the context of this statement is taken to refer to sharing experiences with colleagues and tutors. However, this statement implied that Sarayah had a greater awareness that confidentiality can be breached, although she did not elaborate on this. Yet, Sarayah begins to demonstrate that she has a greater understanding of when it is appropriate to divulge information and is able to distinguish between the objects of confidentiality, which includes personal identifiable data and professional or organizational practices. In the context of patient care, personal data is information that is required to be protected and the focal point of the discussion.

Environments of care and effect on confidentiality

Nadia observed practices pertaining to confidentiality that contrasted to Sarayah's experience:

> *Nadia - Confidentiality is a main thing as well. I was once in what was meant to be an orthopaedic outpatient clinic. So, within the clinic there were 3 or maybe potentially… yes 3 doctors, so running a clinic simultaneously. So, there would be 3 different patients seeing 3 different doctors and then they were being examined without curtains being pulled or doors being closed. Anyone could just come in and interrupt…*

In this example, confidentiality is compromised by the physical environment of the clinical area. Yet, Nadia identified aspects of staff attitudes that resulted in a breach of privacy and / or confidentiality by stating that "Anyone could just come in and interrupt", and talked about curtains not being pulled and doors not being closed. Nadia also highlighted that there are issues with the clinical environment that are beyond the control of the doctors. This accounts for the possibility that it is these factors that impede the doctors from fully observing patients' confidentiality. The (lack of) resources available may be a result of attempts to deliver care to growing numbers of patients, thus creating difficult practice conditions. Samyyah shared her observation with regards to a lack of resources:

> *Samyyah - …there is not much privacy. But in terms of your history, the other patients will just hear it. We just don't have the space.*

Her statement denoted that there is a large number of patients to be seen and that they are accommodated within a finite space. This alluded to the fact that the doctors' actions in maintaining confidentiality were limited by the resources in the care environment.

There are defined differences in doctors' attitudes to matters such as patient confidentiality between the private and public hospital services. What the participants identified through highlighting these differences in practices is the lack of equality that exists between private and public sectors. However, the participants did not have experience of the private healthcare system in the UK and thus could only share experiences of confidentiality within the NHS.

In the previous section there is discussion of the participants' identification of the ward environment being a barrier to the maintenance of patient confidentiality. Pei-Jing commented on the close proximity of beds in hospital wards and how this led to other patients and visitors hearing what was happening to patients:

> *Pei-Jing - If you want to imagine a situation of a typical setting in Malaysia, and how the ward is like, in the more busy ones, I'm not sure about the more rural hospitals, the wards are just…., the amount of patients is so huge that the beds are right next to each other, no matter how much confidentiality you put in. It's impossible because the patient next, on the next bed, everything is shared.*

Pei-Jing's description of the ward environment concurred with the descriptions offered by Cheng in relation to the positioning of beds and patient numbers, and the difficulty in maintaining patient confidentiality in the ward environment. Pei-Jing was not describing the clinicians' stance on the maintenance of patient confidentiality; she was simply describing how the physical environment of the ward and the closeness of beds does not prevent others listening to discussions between doctors and their patients. However, breaches of confidentiality are not uncommon in any clinical setting and often are not intentional moves on behalf of clinicians to cause

breaches. Lian observed the way in which patient data was handled on her placement in Malaysia. In some hospitals she observed:

> *Lian - …the doctors use their own mobile phones and text the information and other stuff and blood results. I thought to myself about patient confidentiality, but they don't have a bleep system.*

Lian illustrated in this example that the handling of patient information is based on the resources available within the health system. Although she identified that using mobile telephones could compromise patient confidentiality, yet she also understood that due to not having a bleep system this was common practice as a practical measure in the delivery of care.

Although the participants spoke of the differences they observed between Malaysian and UK clinical environments with regards to the disclosure of patient information, they also demonstrated contextual similarities that resulted in incidental rather than deliberate breaches in patient confidentiality. In both Malaysia and the UK patient information is disclosed to the family. The participants have presented evidence that although in Malaysia it is considered more acceptable to share information freely with the family, the patient is still consulted or informed that this will take place, although there is an assumption that disclosure will occur. Although the participants have presented a greater need for patient consent in the UK environment, in both countries the participants have shown that the patients are consulted and thus practices are not greatly dissimilar. However, across both cultures the role of the family is seen as an integral part of the provision of care, and thus the family require information and explanations in order to reach a decision in the best interests of their relative.

The participants demonstrated their understanding of the various approaches to confidentiality adopted within the care environments to which they were exposed. They further showed their understanding of the factors that influenced the approaches adopted, some of which were observed to impact other aspects of patient care, including those of privacy and dignity.

Issues of equality in the clinical care setting

Earlier in this chapter, the issue of equality was explored within the discussion of not all patients in similar circumstances having access to the same care. Inequalities within healthcare settings had been earlier discussed as being influenced by cultural and religious beliefs, but also differences were observed between state-funded healthcare and private medical services. Eu-Meh reported her observation of government and private services:

> *Eu-Meh - …so the more affordable ones (wealthier patients), they will prefer to go to the private ones… Why not go and get something more, you can get the results quicker and you know, things like that…*

There are two factors raised from Eu-Meh's comments. The first relates to the practical differences between the private and government-run facilities, particularly in this instance the efficiency of obtaining laboratory results. However, Eu-Meh talked about "getting something more" when attending for care in the private sector, but didn't indicate what is meant by this. In the following part of her interview, Eu-Meh gave an example of a patient she observed:

> *Eu-Meh - …a patient went for a biopsy and had no choice but to wait for two months for the results. And that period of wait, you are so worrying about the condition, and there is nothing else you can do, just wait.*

Eu-Meh demonstrated that empathy for the patient, particularly taking into consideration the amount of worry that a long waiting time could bring, was therefore not an issue faced by those being cared for in the private sector. Eu-Meh also talked about there being "no choice" and "nothing else you can do" when waiting for results. Eu-Meh's statement distinguished between the fact that wealthier patients have a choice as to which hospital they wish to attend, implying that less wealthy patients do not. Thus, the financial status of patients in this setting directly affects the choices available to them as well as their ability to make such choices. These phrases denote that for patients from less affluent backgrounds there is a lack of control over

one's own wellbeing and disempowerment. Eu-Meh's earlier statement of "getting something more" from care in the private sector therefore related to more than the practicalities of care, but also the reduced level of worry and added sense of control and empowerment over one's own care. In addition to Eu-Meh's observation, Liwei stated:

> *Liwei - Unlike in Malaysia, because although the system, the healthcare system is similar, to the NHS, we get free medical care, treatment but the quality they are providing is still not good enough so people still prefer to go private. And then the waiting is so short. If you have a symptom, you can have a CT or MRI scan today and then you know the results will be back tomorrow and you can start treatment in the next few days. In this country (UK) we still sometimes have to wait a few months, but you do have the 2 week rule.*

Liwei's observation of the Malay health system reflected that of Eu-Meh in regards to the practical benefits of the private healthcare system. Liwei elaborated by highlighting that obtaining the results of investigations faster will enable a patient to commence treatment promptly. Liwei acknowledged that waiting times do exist in the UK NHS, but used the two-week rule for cancer patients as an example of how all patients with suspected cancer are prioritised for prompt treatment. Therefore, in addition to the issues of empowerment and control posed by Eu-Meh's earlier statement, both participants indicated how practical factors such as the efficient processing of investigations (scans, blood results), can result in the earlier treatment of conditions. The participants could identify issues of waiting times in both healthcare systems, but could also see how in one system measures had been taken to ensure faster treatment for specific conditions. Liwei perceived this as being due to the fact that in the UK and the NHS "everyone believes that everyone deserves healthcare equally". This denoted that Liwei identified issues of equality within clinical practice. However, some participants demonstrated an awareness of how the private sector and the NHS in the UK collaborate to provide patient care and how patients can move between both systems:

> *Eu-Meh - …like here I do understand they do refer some patients to private. Like I think one of the doctors here. So, if they can't do anything much, and you want something more advanced, NHS can't do it because*

> *you don't fit into the criteria, then you can go for private if you can afford the sum of money.*

Eu-Meh raised the point that patients are referred into the private sector by their NHS physicians, as opposed to patients simply opting to seek private medical care. Yet many of the other participants did not demonstrate having this knowledge and consistently spoke about the NHS in the UK, overlooking the private sector and patients' ability to access care within both systems simultaneously. Guan-Yin raised the following point, in which she drew attention to both government and private health systems and the differences in the quality of care delivered between these:

> *Guan-Yin - …in Malaysia, we have both government and private hospitals. In the government hospitals they pay less, but the quality is not as good as here (UK).*

Guan-Yin's observation drew on her knowledge of the NHS as a government system, which she focused on as a benchmark for quality of care within a state-run hospital. From these experiences the participants began to develop an understanding of the influence of healthcare settings on patient outcomes, patient control, choice, empowerment and equality. The practical aspects of care identified by the participants, such as prompt treatment, were specifically referenced as minimising patient harm by a disease, if treated quickly:

> *Eu-Meh – …so we have to treat them equally, in my contract here, because I've been here, it really feels that in Malaysia the doctors aren't treating the patients very equally, because you can see the difference from one bed to another.*

Eu-Meh's observation probed beyond a general observation. She stated that "you can see the difference from one bed to another." Eu-Meh drew attention to the diversity of patients within a ward environment, and that the doctors' approach is dependent on the patient. Eu-Meh's discussion progressed from being about respect to highlighting the principle of justice. A relationship exists between both respect and justice. Having respect for a patient's personhood is respect for their right to have equal treatment. Eu-Meh demonstrated her awareness and knowledge of justice

through presenting her observations, but without identifying the principle as such. She continued her discussion of how patients are discriminated against based on the way they present:

> *Eu-Meh - If in the bed there is a well- educated, well-kept patient, as opposed to an immigrant who are not well-kept, who are very poor, quite dirty, the way the doctors act are totally different. And the time spent with the patient is lesser (in Malaysia).*

Eu-Meh's account highlighted that clinicians only give their time to those patients of a certain level of education. The difference in how patients are approached based on social class and education was discussed by many participants. Sarayah had observed this when she described wards being categorised as 1st, 2nd or 3rd class for patients of varying social rankings. These discussions continued to align themselves with the principle of justice. The ethical issues raised by these accounts related to the fact that, irrespective of their social status, patients are human beings, and by virtue of being human it is dignified and respectful to receive equal treatment.

Privacy, dignity and respect for patients

The number of patients within a ward area or clinic, their close proximity during examinations and the observing of patients by students had all made an impression on the participants. Privacy, dignity, confidentiality and consent are closely related ethical dimensions of practice. They impact on how care is delivered, particularly with reference to whether care is delivered in a manner that diminishes or promotes privacy and dignity. In addition, maintaining privacy in itself protects both confidentiality and dignity. Lutfi provided an elaborate account of his experience where he observed a combination of factors, including the physical attributes of the clinical area, interrelating with the attitudes of the staff regarding dignity and privacy:

> *Lutfi -There are two tables attached to each other and the patients are sitting with backs facing each other, and they could actually… and there was only one examination couch with a curtain so patient came in and I*

needed to do a PR exam, so I was "ok" but I looked, we had a communication problem because she was from Vietnam so we tried to explain as much as we can that we needed to do a PR exam, and if they were happy for me to do it, as there was another patient present in the same room. Yeh, so it was a bit…. And there was no chaperone at all. When I encountered that problem, I thought, "It shouldn't be like that", and I didn't know what I should do. I asked one of the junior doctors what I should do, and if there was another couch for me to do it, as I didn't feel comfortable, and the doctor said, "No its fine just go ahead!", and I was like "ok!". Then the next thing was a lady with a chest problem and the patient is willing to.. you know.. to like take off her clothes to do a proper examination of the chest and again there is a male patient in the same room(…)

Lutfi raised other issues in addition to those of the physical environment and its impact on dignity and respecting patients. He spoke about performing a PR (digital rectal examination) whilst there are two patients in the same room. In this example, Lutfi considered the impact the lack of privacy had on the patients by expressing concern about patients being in close proximity to other patients, particularly those of a different gender. Lutfi remarked on how both these patients were women and highlighted that he felt uncomfortable and that there was no chaperone, while also noting that there was a male patient in the same room, whilst caring for a female. Lutfi spoke of how he expressed concern about this situation and explored alternative options in order to examine and treat the patient in a more private setting. Yet, Lutfi also described how the attending junior doctor dismissed his concerns and encouraged him to continue with the procedure. This situation made Lutfi feel uncomfortable, but there was also an element of conflict between his understanding of how to treat the patients in a respectful, dignified manner and what the reality of this situation involved. In the latter example, he described a female patient exposing herself in the presence of a male patient, but did not discuss the cultural or social norms associated with the exposure of women's body parts. However, he seemed taken aback by the female patient's willingness to "take off her clothes" in front of another patient. Meanwhile Alwi expressed his concerns when he spoke of Muslim women being exposed to numerous medical students, and staff not attempting to seek a female doctor for this situation. However, it is implicit from both Lutfi's and Alwi's comments that they perceived exposure of the person as unacceptable.

The above example from Lutfi illustrates how he attempted to act as an advocate for the patient in his effort to find a private space in which to perform the rectal (PR) examination. The participants expressed feelings of being uncomfortable in such situations, with Lutfi's account demonstrating his feelings of uncertainty about the appropriateness of the situation, and whether the examination should be performed under those conditions. Comments such as those by Lutfi suggesedt that these practices conflict with their understanding of dignity.

Sarayah commented, in the following extract, about "many women giving birth" in one room, and indicated how she would seek to protect her own self-respect by seeking alternative services:

> *Sarayah - We were brought in through a door that goes straight through the labour room, with many women giving birth, and they seemed fine, and there were no curtains. And there was health attendants, some men, and I just thought, "I don't want to give birth here!" They didn't ask consent from these mothers, they didn't ask these mothers. I don't know if it's because it was a 3ʳᵈ class ward. At the time I didn't know anything of the health industry. So, I guess that consent and privacy is not that important in Malaysia.*

Here she highlighted the lack of privacy and consent that these particular women experienced. She did question these circumstances and whether these conditions were related to the type of healthcare service: 3rd class. This example highlights how patients' bodies were exposed and the vulnerability of these patients. These types of descriptions that were offered by the participants suggest that they were aware that dignity and respect is not equally addressed across all the clinical settings where they had practice placements.

Sarayah drew a comparison between her experiences within obstetric settings during her labour ward placements in the UK and Malaysia. Her account captured a variety of issues with regards to her impression of the clinical environment in the UK.

She added:

> *Sarayah - And when I came here and I was on labour week, I saw the women get their own room with a bath tub, and some can even have a water birth…*

In this extract, the main difference that Sarayah observed was that of the number of women within the same space who were giving birth and the fact that they did not have curtains to protect their privacy. However, in her experience in the UK, she noted that women had individual rooms and were thus not exposed to each other. The extracts from Lutfi and Pei-Jing indicated that they also shared the observation of patients being able to see each other.

However, in light of the participants' comments relating to the large numbers of patients on the wards and clinics, it was suggested that it is the service provision and the clinical practice environment that undermines both patient dignity and the clinicians' ability to uphold the respect and dignity of their patients. Thus Lutfi, Alwi and Sarayah implied that the concept of dignity varies within different contexts, which could be due to culture or provisions and resources within the environments of care they were exposed to.

Conversely, Nadia shared an experience whilst on placement with the aborigines in the Malaysian forests, whereby indigenous tribes would walk around naked within the hospital. Although Nadia was surprised by this experience, it did not elicit the same response from her as Lutfi's experience did (discussed on page 141). Nadia's description illustrated how the service supported the aborigines to behave in a manner that was customary for them. In Nadia's case, when she spoke about "the forest people" it was clear that, for these individuals, nudity is not undignified.

> *Nadia - We can see it's completely different like, they can walk around the entire hospital without wearing clothes, but that is normal to them…*

Similar to Nadia, Lufti's patients may also have felt that exposing oneself in the company of others was the norm. The participants didn't suggest why some behaviours or aspects of care which they deem inappropriate are not seen as such

by the patients. Liwei commented on why patients do not complain, or to use Sarayah's words, "seem fine" with these practices:

> *Liwei - …because we were brought up in HN, nobody has seen like healthcare here, so they don't know what they are supposed to have… a quiet room, some privacy… I think they just get used to that. As far as I can remember, there would be a couch behind, with a screen and any patient with an examination would go on the couch and pull the screen to have the examination.*

Liwei described his awareness of ways in which patient privacy, respect and dignity could be upheld by offering the patients a quiet room, as his previous observations (in Malaysia) indicated that patients would be protected by a screen when examinations were conducted with others in the same room. According to Liwei's statement, the patients do not challenge these practices because they are not aware that alternatives exist. He uses the words "they don't know that they are supposed to have, a quiet room, some privacy." This phrase denotes a sense of entitlement to these qualities, where he could have used the word "could" to imply that privacy and a quiet room would be optional for the patient. Yet Liwei observed that privacy and a quiet room are something which patients are "supposed" to have, stating that patients get used to certain practices, appearing to refer to the lack of privacy. However, his statement has nuances that imply that if the patients were made aware of what they are "entitled" to, they would therefore be empowered to ask for a private space. Thus, by the same token, the patients could in turn become "used to" these practices, as they thus become the norm. Samyyah shared a similar observation:

> *Samyyah -… they (Malaysian hospitals) have two to three beds in one curtain and in A&E there are two patients in the one curtain. They (the doctors) will examine a trauma patient in front of a child.*

This example not only raises issues of a lack of privacy and dignity for patients, but also issues of safeguarding of children. In this situation, children are not protected from observing specific medical examinations, and may even be placed within close proximity of another patient. Samyyah's statement also alluded to the possibility that the child could be examined in the presence of others when in a vulnerable position. In contrast to this, Sarayah was surprised by all women getting an individual room with en-suite facilities. The sentence, "I saw the women get their own room with a

bath tub" captures a greater issue than that of dignity and privacy, but one relating to a sense of equality or perhaps privilege via the use of the term "the women get." This captures the sense that all women will have their own room, irrespective of social background. Sarayah perceived that having individual rooms was a positive aspect, and that mothers do not have to ask for this, as the decision has been made by the organisation to provide these facilities.

In addition to the above Sarayah added, "some can even have a waterbirth," which suggests that she viewed choice in birthing experiences as very different to what she has observed here, as well as in other cultures. Sarayah demonstrated that privacy, respect and dignity are not elements of care which in this observation require a conscious choice on behalf of the patients, alluding to the fact that within the care environment in the UK, this is an entitlement for the patients.

What has been highlighted here, are not simply matters of the physical structure of the ward environment, but those that related to attitudes and behaviours of staff. However, what has been presented are complex issues relating to dignity. The participants spoke of feeling uncomfortable when observing or experiencing some practices. In addition, they demonstrated feeling a sense of conflict when they felt that their duties and responsibilities to their patients were inhibited by service provisions, the environments of care, and lack of resources.

Compassion

The participants spoke about their varied observations of care issues, such as addressing psychosocial or emotional needs of patients, alongside their biomedical needs. However, offering a more compassionate and empathic approach to the consultation was not evident across all clinical settings. Lian described her observations of approaches to care that often did not meet the emotional needs of the patient:

> Lian -... in my observations on my placement in Singapore, Breaking Bad News is delivered quite directly and the patient is not offered much support.

> *In Malaysia, it is quite abrupt and the patient doesn't even know what they have...*

Lian described what she viewed as normal practices whilst on these placements. She discussed how the doctors' deliver the information quite directly and abruptly and she spoke about the patient not being offered much support. Lian further emphasised that in the interactions she observed the diagnosis had not been accurately conveyed to the patient. Lian's comments on the delivery of bad news share some similarities to Jia's statement on p.107. Jia used the words "not nice" to describe the approach of the doctors towards patients, and suggested that through focusing on curing the disease the purpose of the doctor-patient interaction was achieved but lacked empathy and compassion. By stating that in the end "they will want to get the disease…", Jia implies that the ultimate goal of medical practitioners is to treat or cure. According to Jia, in Malaysia this is achieved in a manner that does not account for the patient's perspective, yet her observation demonstrated the opposite approach to that experienced by Nadia and Sarayah. This shows that there are a variety of approaches of care throughout Malaysia, yet not all the participants were exposed to these, and these experiences shaped their perceptions of care. Throughout, Jia demonstrated a preference for the empathic approach in the delivery of care. She gave an example which related to the delivery of bad news to a patient:

> *Jia - I don't think they have a way of breaking bad news, it doesn't really, matter in Malaysia. You can just tell the patient and of course they will think they will definitely be sad, but it's not really my job to care about if they are sad or not. That's probably for the family. So, It's not really, that important in Malaysia. I don't think that that's good though. I think it is better you know… but that's just how it is in Malaysia.*

Jia showed one approach to breaking bad news, reinforcing that the emotional aspects of care are not at the forefront of Malaysian clinical practice. Although in the extract below Alwi demonstrated his preferred approach to delivering bad news by way of being direct, he did also present his knowledge of the different approaches he learnt throughout the course:

> *Alwi - …how do you Break Bad News? Some people say you should get someone in charge. Others say you should just say it directly, don't beat around the bush. My approach, because of the way I am, is just say it, but*

> *some people don't. They say it depends on the patients and whether they want a bit of a slow build up to the news and not to say it directly. My problem is, I don't know which one patient wants whether it is a direct shot or a build-up shot.*

Alwi spoke about getting someone in charge to deliver bad news, demonstrating his awareness of having a senior member of staff to speak to the patient. He also appreciated the need to take into account the patients' preferences as to how they wish to receive news of a serious nature.

In her earlier extract, Jia expressed that "it is not good enough" that doctors do not acknowledge patient emotion, indicating that there is an alternative approach to delivering bad news. Although here, Jia used the word "my", in this context Jia related to the doctors that she had observed and not to herself as a practitioner. Jia drew attention to the expectations associated with the role of the family and that of the doctor, describing a situation whereby it is the responsibility of the family and not the doctors to address the patient's emotional needs. In both statements, Jia has reiterated that such practices are "the norm" or "how it is" in Malaysia, denoting that this is a cultural norm or accepted practice.

When depicting empathy and compassion, Jia has used words such as "nice" and "care." Lutfi, however, used the term "soft skills" when discussing empathy and compassion:

> *Lutfi - …it's a complex thing, to have the "soft" skills, the skills around it, with the knowledge of medicine, "Give this medication, go home...". But because you are treating a human, it's not as straightforward as that, and when you talk to them, it's not as simple as that.*

In discussing the doctor-patient relationship, Lutfi highlightrf that treating a human is more complex than treating a disease. His words "when you talk to them", evoked a sense of medical care being more than merely treating the disease. "Talk" carried connotations of in-depth conversations occurring between patient and doctor, including discussions of an emotional nature, as opposed to describing a medical complaint in a scientific manner. Lutfi proposed that the interaction between a doctor and a patient is more intricate than simply addressing the disease process, requiring

exploration of the patient's needs beyond the realms of the disease. Lutfi used the example of prescribing medication to signpost towards the relative simplicity of the inanimate tasks associated with patient care when compared to the complexity of incorporating "soft skills". With this example, Lutfi indicated a task-focused approach to care which lacks compassion and empathy:

Guan-Yin spoke of her experience of compassion when caring for a patient at the end of life.

> *Guan-Yin - But after 3 years here I think that communication skills are important for our patients-doctor relationships. I am quite surprised that here (UK) we have End of Life support. I think that it is very good. It's fantastic, even if you have cancer, you are still dying, but we still care for you. They still provide you something, rather than in Malaysia… I don't know how but I just think that we don't have these kinds of things.*

Guan-Yin expressed her appreciation of end-of-life care support provided by clinicians. She referref to patients being cared for even if they are "still dying". This infertrf that patients are still treated as individuals, even if their condition is terminal. Although Guan-Yin did not use the words "compassion" or "empathy," these are implicit in the tone of her statement as she acknowledged that although little can be done from a biomedical perspective, the provision of care continues.

Others, e.g. Alwi, spoke of experiences in general consultations whereby they had observed that a lack of compassion was exercised by not exploring the patients' ideas, concerns and expectations.

The participants inferred that compassion and empathy were an important part of the doctor-patient relationship. In an earlier statement, Jia discussed that doctors in Malaysia did not consider comforting the patient and addressing emotional needs as part of their role, and how she felt that this "was not good." Guan-Yin had a contrasting experience and shared her thoughts on addressing patient needs beyond the biomedical perspective in the extract below.

In his interview, Alwi spoke about his observations of the doctor-patient interactions and his observation of doctors often focusing on the biomedical aspects. In the following extract, Alwi shared his thoughts about an alternative approach to doctor-patient interactions:

> *Alwi - it's not that I disagree with empathy, and smile and whatever, it is important. Basically, sometimes when you with the patient in a nice, in a comfortable way, you make the patient comfortable, you cure half of the disease. I mean it's true, I really understand that…*

Alwi highlighted the positive impact that demonstrating empathy and treating the patient in a nice or compassionate manner can have on the curative process. He demonstrated an understanding that human interaction with the patient is of equal importance to the consultation and treatment as the medical knowledge. Alwi described a compassionate approach to care whereby addressing the psychosocial aspects in the consultation can be a beneficial component of care.

Doing no harm

Doing good and doing no harm were principles of care which were raised by the participants. In his interview, Kueng spoke about both of these but attributed doing good to his religious faith:

> *Kueng - Yes, I think it does because they (religious doctrine) say to do good and to do no harm, which is basically the Hippocratic Oath. So actually, it does help, being a Buddhist. Not just being a Buddhist, because all religions would ask their disciples to do good and hopefully we would have a peaceful world.*

Kueng linked Buddhist teaching with concepts inherent in the Hippocratic Oath, indicating that he perceived there to be a link between religion and the medical profession's code of conduct. Kueng further attributed the concept of doing good to that of doing no harm, as raised by other participants within their interviews. But Kueng captured it succinctly without the use of precise terminology such as

beneficence and non-maleficence, which are the terms utilised in the definition of these concepts within the ethical theory of principalism. However, it is not the terminology that was used to describe this which is of importance, but the participants' ability to identify and describe the ethical dimensions of practice to demonstrate their understanding. Other participants, such as Alwi, also made reference to the concept of harm and doing good.

> *Alwi - But I really, like emphasis on basically the body and disease, clinical, but not really ethics. I do appreciate it (ethics), and as, long as I don't do any harms, then its ok (laughs) as long as I don't misdiagnose a patient and poison him with different drugs…*

Here Alwi used examples such as misdiagnosis of a patient's condition or poisoning to demonstrate his understanding of harm. However, in this context Alwi provided examples which related to both physical and non-physical aspects of doing good and doing harm. He demonstrated his understanding of the relationship between decision-making and respect for patient choice when speaking of doing no harm, and thus drew attention to the non-physical features associated with harm. However, throughout the above Alwi spoke of "not going to harm the patient" and "as long as I don't do any harm," but yet did not state the phrase "to do good." Here, Alwi was illuminating the aspect of what is widely defined as both principles of non-maleficence (to do no harm) and beneficence (to do good). However, Alwi proposed what he considered "to do good" when he stated that he agrees with the concept of having patient involvement in care and a doctor-patient agreement. Therefore, for both Alwi and Kueng, beneficence and non-maleficence appeared to be two key principles that were implicit in the provision of care that they observed. Alwi spoke of how patients' rights would be ignored with a view to do good or do no harm. In the extract below Alwi described a situation whereby a woman would not normally consent to a male doctor:

> *Alwi - …they would just ignore the patient's rights. The doctor would just come in and do it to make sure the patient is safe. That's the thing, that's the best way.*

This is an insightful comment and relates to Alwi and Kueng's views of doing no harm. Here, Alwi identified that the overriding principle that guides practice in this situation is patient safety and, in such instances, there is more good and less harm achieved by overriding patient autonomy and choice. Alwi demonstrated an understanding of these principles and how they are best applied to a clinical situation. Alwi's experiences and observations of clinical practices within different contexts informed his understanding that there are a variety of different approaches to practice and patient care.

Chapter summary

The participants' demonstrated their ability to identify the ethical dimensions of practice such as patient choice, consent and confidentiality, within the varying clinical settings. Their exposure to these situations heightened their awareness and sensitivity to the ethical dimensions of practice, as they gained insight into how the use of these ethical dimensions were incorporated within the cultural and societal norms of the environments of care. From this, the participants demonstrated a degree of conflict related to the appropriateness of the actions and behaviours they observed. They demonstrated struggling with circumstances whereby the optimal course of action was inhibited through factors beyond their control, such as available resources. This did not only cause conflict but also led to a level of uncertainty about the most appropriate decision or approach to practice.

The participants demonstrated that they had developed a degree of ethical sensitivity by the fifth year of their medical education. Ethical sensitivity constitutes a person's ability to assess/interpret a situation, identify the ethical issues and draw a conclusion as to the appropriate response to the situation, whilst accounting for the needs of the patient receiving care (Ersoy & Gundogmus 2003; Weaver 2007). They drew attention to issues of consent and patient choice when discussing the means through which they developed their understanding of the ethical dimensions of practice. Diverse experiences in approaches to healthcare shaped their understanding that healthcare can be delivered in different ways. Although on the one hand this can enhance their understanding, these experiences also caused them to challenge what they were observing. Their discussions highlighted the

impact of their observations of interactions with patients, their reflections on communication with patients and how all these experiences are part of how they become aware of the ethical dimensions of practice.

This chapter has provided discussion about what the participants understand by the ethical dimensions within healthcare practice. Their discussions have illustrated the complex scenarios in which they have observed the ethical dimensions being utilised in the clinical area and how these experiences, together with the participants' own personal beliefs and values, have influenced the development of their understanding of the ethical dimensions of practice.

The following chapter presents the findings derived from further in-depth analysis of the experiences and understandings that were discussed by the participating medical students. The following chapter will present a model of ethical sensitivity that portrays the experience of students completing a partner medical school programme.

Chapter 6

Factors influencing ethical sensitivity of students on a partner medical school programme

Introduction

Chapter 5 explored how students on a partner medical school programme develop an awareness and understanding of the ethical dimensions of practice. The factors that influenced and impacted the participants' understanding of those aspects of practice were also discussed, thereby addressing objectives 1 and 2 of this study: to explore how Malaysian medical students develop an understanding of the ethical dimensions of practice; and investigate factors that may influence or impact the students' understanding of the ethical dimensions of practice. Further analysis and interpretation of these findings led to the development of a conceptual model of the factors that influence the way in which students on a partner medical school programme develop ethical sensitivity in their healthcare practice. This model is described and presented in this chapter.

Introduction to the model of ethical sensitivity

The model consists of two elements that were derived from further thematic analysis and interpretation of the findings. These elements reflect the participants' understanding of the ethical dimensions of healthcare that developed through their educational and professional experiences when studying in two different countries. The participants observed different approaches to care, such as how privacy is maintained and dignity upheld in various situations (see for example Lutfi p.141 and Samyyah p.135). Lutfi observed an invasive test, a PR examination, being completed in a setting where the patient was near to others with only a curtain separating them. Samyyah described women delivering babies in very public situations in one environment, a sharp contrast to other settings where women could choose to deliver their baby in a private room. The students observed different

approaches to practice and this led to confusion and uncertainty regarding the appropriate action to take. It is argued in this chapter that this uncertainty led the participants to experience cognitive anxiety. They drew attention to different clinical practice that occurred in Malaysia and the UK. Similarly, with context in mind, within one culture it may appear that the treatment of patients may be deemed to be dignified, yet the same practice may not appear to be considered so in another. However, the arguments presented by the participants illustrated that within certain cultural contexts priority was awarded to other prima facie values e.g. within some of the clinical settings in Malaysia, privacy was not protected due to the number of patients and space available in clinics, yet this system ensured that all patients had access to healthcare. These variances in experiences contributed to uncertainty in the participants and they questioned what the right course of action in these scenarios would be. As they completed more placements, they became aware that there was more than one approach to the delivery of healthcare in similar practice situations. They also struggled to make decisions about what the approach should be adopted rather than simply appreciating that different approaches exist. Hence cognitive anxiety arose as a result of these students experiencing conflicting beliefs, values and experiences, and their struggle to decide the course of action or practice that they should implement. It is argued in this chapter that the uncertainty that these medical students experience contributed to them experiencing anxiety as they considered what they ought to do in a given clinical environment. It was this anxiety that develops ethical sensitivity.

Ongoing awareness and development of understanding, and cognitive anxiety, influenced the development of the participants' sensitivity to ethical issues inherent in healthcare practice. For purposes of description these aspects of the participants experiences were described as elements. Hence the term 'element' was adopted to to describe each part of the model. The model presented in this chapter is an abstract construct and, according to the Oxford Dictionary (2017), elements are "essential or characteristic part of something abstract." The following figure illustrates how each element of the model contributes to the student's understanding of what they are experiencing in practice and how this ultimately influences their sensitivity to ethical issues and dilemmas that are inherent in healthcare.

Diagrammatic model of the factors that influence ethical sensitivity to the ethical dimensions of healthcare for students on a partner medical school programme

Understanding of the ethical dimensions of healthcare

Cognitive anxiety

The point at which both elements overlap depicts ethical sensitivity to the ethical dimensions of practice
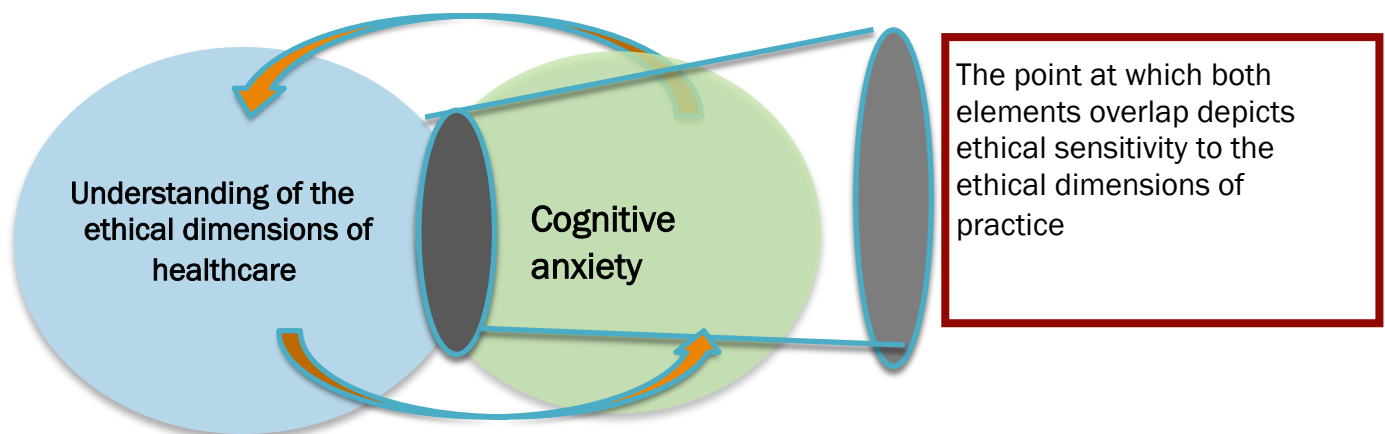
Rationale for the use of concept analysis as a framework for the presentation of the model of ethical sensitivity

In this chapter, the ethical sensitivity model is presented and discussed using an adaptation of concept analysis (Rodgers 2000). This approach to presenting the model provides a framework for exploration of the factors that influence ethical sensitivity, thus offering an in-depth explanation of the model. Concept analysis models are widely used in the explication of concepts, aiding researchers in presenting a logical and detailed argument on the concept they are analysing. A concept analysis framework is used here as a means for presenting a structured discussion that will lead the reader through the process of the development of the model.

Concept analysis

Various concept analysis frameworks are in existence, with the earliest framework for concept analysis being proposed by Wilson (1963). This has been influential in the analysis of concepts through the means of presenting related cases. In contrast, Rodgers' (1993) approach features identification of antecedents, attributes and

consequences. A cyclical approach is proposed, with the aim of enabling the analysis to reflect the dynamic, changing nature of concepts over time due to their relevance and use at a specific point in time (Endacott 1997; Bonis 2008). Rodgers' (1993) evolutionary concept analysis offers an inductive method of analysis and thus is in keeping with the methods and methodological approach in this study.

Rodgers (1993:331) concept analysis allows for description and analysis of concepts related to less tangible aspects of human life such as cognition, emotion or behavior. This process aligns with the qualitative paradigm and its associated methods, such as semi-structured interviews, that are designed to explore the ideas and emotions that humans experience. Rodgers (1993) considers various methods of data collection in concept analysis, including interviews and other "verbalised language" (Tofthagen & Fagerstrom 2010:24). This evolutionary model moves away from empiricist approaches to concept analysis, offering an epistemological approach that does not reject the metaphysical. It concerns itself with concepts of being, knowing, identity, time and space which align with the Heideggerian philosophy (Heidegger 1967) that has been adopted in this PhD study, thus making it suitable for presenting the model of ethical sensitivity in the context of partner medical school education programmes. The approach to concept analysis offered by this method offers a phased approach which includes considerations that can be applied to the analysis of a concept as illustrated in the following table.

Table 14: Rodgers '(1989 &1993) method of analysis (revised version)

Identify concept of interest	Selecting the topic. Identifying the relevant literature
Surrogate Terms	Do other words say the same thing as the chosen concept? Do other words have something in common with the concept?
Antecedents	Which events or phenomena have been associated with the concept in the past?

Attributes	What are the concepts characteristics?
Consequences	What happens as a result of the concept?
Related Concepts	Identifying concepts related to the concept
Examples	Are concrete examples of the concept described in the data material? Model cases of the concept

The initial phase (phase 1) of Rodgers' model was not suitable for this study as the concept was an original idea derived from the findings of this study. Whilst concept analysis can be applied as a research approach, in this study concept analysis was applied for the purpose of providing a clear presentation and explanation of the findings. Therefore, the processes of searching for a concept of interest and searching surrogate terms were not applied, as the concept analysis did not relate to a concept that existed. The core analysis phase was applied through presenting antecedents, attributes and consequences of each element of the model, together with the provision of examples from the findings to highlight each of these elements and outcomes. A further adaptation was that these were not presented as model cases. Phase 3, further analysis, is considered in the discussion chapter within the section on future recommendations.

Understanding of the ethical dimensions of healthcare

The element of the factors influencing the understanding of the ethical dimensions of healthcare, together with its antecedents, attributes and consequences will be presented and discussed in this section. Figure 4 offers a visual representation of this element of the model and its corresponding antecedents, attributes and consequences.

Fig 4 – the antecedents, attributes and consequences of the factors influencing the understanding of the ethical dimensions of healthcare

Antecedents
Being on a partner medical school programme
Culture
Religious Values
Family
Socioeconomic status

Attributes
Ability to identify ethical issues
Accounting for patient needs
Ability to assess/interpret a stiuation

Understanding of the Ethical Dimensions of Healthcare

Consequences
Accounting for context in clinical decision-making and care
- Interaction with patients in different cultural contexts
- Culture and compassion
- Expectations of acceptable healthcare practices

Antecedents

The factors which influence an individual's understanding of the ethical dimensions of healthcare are culture, religious beliefs and values, the role of the family or informal caregivers as supporters and the impact of socioeconomic status on the delivery of clinical practice. Exposure to various practices and situations through the varied clinical placements that are completed in a partner medical school programme had a significant influence on the participants' understanding of clinical and ethical decision-making in healthcare practice.

Partner medical school programme practice experience

The very nature of the partner medical school programme provided students exposure to two distinct national healthcare systems in two societies. Unlike short elective placements of a 6-8 week duration, that are offered on most medical degree courses, partner medical school programmes include longer overseas placements (3 years in the research setting). The findings presented in Chapter 5 are evidence

of the variety in clinical ethical practice which the participants encountered throughout the programme and how this shaped their outlook on patient care.

In Chapter 5, the participants spoke extensively about the varied experiences they had had with regard the issue of informed consent. On p. 110, Nadia spoke of the various approaches to informed consent she observed. She did highlight, however, that the obtaining of explicit, informed consent was not part of the doctor (or student) and patient interaction in some situations. Nadia's perception of this was that being consented for a procedure was not an expectation of the patient. Further details were not provided by Nadia on this occasion as to the circumstances of the situation. However, it is worth considering that often the severity of a condition may override the need for informed consent when acting in the patient's best interest, which was a feature that Nadia discussed when discussing her experiences of delivering healthcare to the aborigines (see p. 115). Yet, she also discussed that within her clinical experiences in the UK, she had observed that obtaining informed consent was heavily emphasised. Similar experiences were also discussed by Alwi (see p. 97) where he indicated that in the UK consent played a pivotal part in the interaction between medics and patients, but its importance was not emphasised in similar experiences in Malaysia.

Consent was one ethical dimension which the participants identified as being distinct within the clinical areas. Confidentiality featured heavily in the participant interviews (see p. 131-137). Discussions of the variances in the use of the ethical dimensions of practice of "equality, privacy and dignity, doing no harm and compassion" were discussed (see p. 138-151). Because of the length of time on their overseas (UK) placements, the participants became immersed in both the culture of the clinical environment and also the country, allowing them to contextualise their experiences. This is a feature which is unique to the partner medical school programme, allowing them to develop an understanding of the ethical dimensions within the different clinical settings.

Culture

Malaysian society is complex and diverse, consisting of a number of ethnic groups. Culture was identified in the participants' accounts of their experiences and discussed at length in chapter 5. Although Malaysian culture is made up of a number of subcultures, the three most prevalent are Malay, Chinese and Indian (Moschin & Ong 2011). The participants referred to Malay culture as a generic term, not differentiating between these groups, when they made comments such as "in Malaysia" or "in our culture." Yet, the participants made reference to specific subcultures within Malaysian society.

Participants spoke of the aborigines who inhabit the jungle in Malaysia. Their experiences of this specific group were clearly impressed in their minds as they provided detailed explanations of their observations of their time with this population. In addition, the participants made reference to other segments of society within the wider population. They spoke of those who are less educated or less informed and live away from the main urbanised areas. They described how individuals within these communities perceived the doctor-patient relationship as one in which the doctor was in a position of authority. The patients respected the doctors and held them in high regard. Their expectations of healthcare were that of entrusting themselves to the doctor and allowing them to make decisions about their health and wellbeing on their behalf.

As an antecedent, culture provided background understanding to the study with respect to the participants' perception of their experiences. This encompassed their understanding of beliefs and values of patients, themselves and people living in a particular society. Sociopolitical influences on healthcare systems, patient access to care, and the economics of healthcare were issues that the participants readily explored in their discussions.

The participants noted that differences existed between the patient cultures of rural and urban populations in how healthcare was perceived. Expectations of care varied between these populations, with those within the aboriginal or those from small village communities having little exposure to a more cosmopolitan way of life, and thus being more accepting of medical practices than those from urban and city areas. Alwi demonstrated an appreciation of the expectations of patients in various settings. Below, he shared his observations.

Alwi - to be honest, in my surrounding… people in my surrounding they are accepting, they have an accepting nature, any medication they give, they just believe, this is nice for him. They just take it, they don't question much. In the city centres and things like that, they might have some questions about their medication. But people in my surrounding, they just accept it so, they don't have like, involvement in the decision-making process, they just accept it. Yeah, that's it. Even myself, I accept what the doctor tells me, it's not going to do any harm to me

Here, Alwi identified two isssues. He differentiated between people in "his surrounding" and those in "the city centres." Thus, Alwi suggested that people from his surrounding are not from the cities and have trust in the medical profession. Alwi drew on his own stance and emphasized how he also trusted decisions made by his own doctors. Pei-Jing shared her observation

Pei-Jing - the majority (of patients) they leave it up to the doctor, but I think that the thinking behind the Malaysian is shifting. The more educated ones are the ones that tell us what they want and what the doctors should do for them. Those are the ones that are like the patients in the UK, and confidentiality is important and our communication skills are put to the test, and all that. But the majority of the community in Malaysia, they are not as alert or more aware of their health issues as we'd like them to be.

Pei-Jing spoke about the patient's perceptions of the role of doctors and how patients are happy to "do as they're told", a view which was supported by participants such as Alwi and Lian in earlier discussions (see p.125 -129). However, the participants presented what they perceived to be the cultural expectations of

patients, and how these expectations influenced whether patients make autonomous choices or enabled their doctor to make choices for them. In the latter circumstance, individuals relinquished responsibility for making decisions about their care to their physicians and this in itself was an autonomous choice and an alternative approach to decision-making. A patient not expressing their wishes may not be as a result of complacency and acceptance of practices, but more linked to having limited access to healthcare, and reduced options on where to receive care.

Ibrah described her experience of cultural influences on patient care in the UK

> *Ibrah – I've had placements in Blackburn, they have a large Asian community there, but their values are different to the Asians here, like they are from a different part of Asia. They seem more….patriarchal. I was quite shocked that these are ladies that have been here (in the UK) for 30 or 40 years but still they can't speak English. I mean, even if they can't understand basic language, they can't make decisions for themselves, it has to be through another person. So what about the confidentiality and things of that nature.*

Ibrah was surprised at the strong ties with their culture that the population within this town had. She spoke of these individuals not being able to make their own choices because of their language barriers and thus questioned their autonomy. She described this group as a patriarchal community in which males exert dominance. She alluded to the women's autonomy being compromised by this hierarchy, and that decisions about their own healthcare are dependent on others. Ibrah had her own ideas about the population in the UK and this experience took her by surprise as she stated that

> *Ibrah – I couldn't believe that this was the UK, where they have the opportunity to better themselves*

Ibrah's impression was that in the UK women have opportunities to develop themselves. She was clearly taken aback when she encountered this community within the UK in which women are reliant on male members of the family and isolated due to an inability to communicate with others outside of their own cultural group. Whilst other participants have presented patients who have made autonomous decisions for physicians to assume responsibility for their care because

of their own cultural beliefs, Ibrah was describing a situation in which the patient's choices about healthcare are dependent on others. However, from her description she did not indicate that this was an autonomous choice but instead based on the social constructs of their community.

In their experiences in both Malaysia and the UK, the participants identified subcultures within the wider culture of these countries. They described experiences in which culture influences the patients' perspective of the role of the doctor and their expectations of a consultation, and how this results in patients making decisions to allow doctors to act in their best interests. In contrast, a situation was encountered by a participant in which cultural influences compromised patients' choices due their gender and their societal constructs.

Religious values and beliefs

Religious values and beliefs played a part in the discussions of the participants. They commented on their own beliefs and how this shaped their approach to clinical practice.

> *Lutfi - You know I'm muslim, we're muslim, you know we have obligations, you know and I thought this when we were in Malaysian hospitals they're Islamic. You know treat the patients nicely, check the prescriptions, you know.. all the details things like that.*

The reference to obligations pointed to Lutfi's duties that he is required to fulfil in his role. Lutfi's statement indicated that his beliefs are grounded in deontology and his his approach to his professional practice was based on duty-based ethics. Therefore, he suggested that the requirement to fulfil duties arise from his religious beliefs as well as his professional code of practice. Kueng also made a connection between religion and professional practice.

> *Kueng – Yes, I think it does because they (religious doctrine) say to do good and to do no harm, which is basically the Hippocratic oath. So actually, it does help, being a Buddhist. Not just being a Buddhist, because all religions*

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would ask their disciples to do good and hopefully, we would have a peaceful world.

Both participants discussed the impact of religious beliefs as a positive influence on doctors' conduct. However, other participants such as Nadia, Eu-Meh and Pei-Jing described religion as dictating what care is made available or considered acceptable within healthcare environments, and that this can contribute to inequality in access to healthcare services (see p.121).

Nadia -. The religion plays a big part in basically dictating how the country is run. Yeh that's it, it revolves around religion mainly. So, any arguments you can make, as long as it comes from the Quoran, then its fine.

Nadia used the word "dictating", implying that there are strict and rigid rules applied in Malaysia. The Quoran enshrines the principles that are used for running the country and she suggested that the national religion forms part of the governance of the country. Other participants, such as EU-Meh and Pei-Jing (see p. 122-123) described how treatments such as abortion are considered unacceptable in Malaysia, as this practice conflicts with dominant values in this society. However, they also argued that adherence to these values is inconsistent in Malaysia because abortion is available in the private sector for those who can afford to pay for this procedure. These accounts presented a wide range of perspectives of how the participants conceptualised the relationship between religion, societal governance structures and healthcare service provision.

The role of religion in governance is a complex issue. These statements alluding to religious dominance over the state as being isolated to Malaysia shows naivety on behalf of these participants. Such issues are encountered in other countries such as Ireland and its views on abortion, and Switzerland and its approach to euthanasia. Although all the participants spoke of religious influences towards care in their interview, with regards to the relationship between religion and governance there was limited discussion.

The family

Involvement of the family in decision-making and care was widely discussed. Families were involved in care decisions as supporters, informants or consultants. Their contribution to care enhanced the potential for providing holistic care, thus shifting the focus from addressing the biomedical needs of the patient to a more comprehensive consideration of the individual's lifestyle. The participants spoke of the cultural landscape in Malaysia as offering an alternate perspective to patient care with the emphasis on community and family involvement. Pei-Jing summarised the role of the family in patient care within Malaysian culture.

> *Pei-Jing -the difference in culture is that in Malaysia it is more of a family setting, that everyone shares everything, even with friends, so any medical conditions they would know. If an elderly, if my grandma were to go in, everyone would know what is happening. The doctor wouldn't ask my grandma "is it ok to show your relatives about what is going on" It is an unsaid agreement that you can tell whoever*

Here Pei-Jing suggested that divulging personal information to the family is a cultural norm, as they (the family) fulfil an important role in the health and wellbeing of the patient. She argued that it is an expected practice that information will be shared with the family and that they will contribute to the ongoing care of the patient.

SOCIOECONOMIC STATUS

In Malaysia, the participants were exposed to communities of varying socioeconomic backgrounds. They encountered communities within rural and urban areas as well as tribal communities in the jungle. The participants made reference to how the socioeconomic status of patients had an impact on their access to care. This was not an issue that was as prevalent in their discussions within the UK health system. In chapter 5, it was highlighted how patients in from wealthier backgrounds Malaysia had access to private healthcare which led to expedient and more person-centred care, as well as a wider range of treatment options.

Eu-Meh (see p.138) described a situation where a patient had accessed care in a state-run hospital and waited for test results for 2 weeks following investigative procedures. In this case, Eu-Meh spoke of the delay in treatment and the worry that the patient had experienced as a resut of the long waiting time. She drew a contrast to the private sector hospitals in the same country where test results would be obtained more quickly, which led to the prompt commencement of treatment.

Through this example Eu-Meh demonstrated her understanding of inequality which derived from a patients' socioeconomic background and their ability to pay for care that existed in healthcare services.

Attributes

The ability to identify ethical issues, accounting for patients' needs and the ability to assess/interpret situations were the key defining features that determined the participants' understanding of ethical dimensions of healthcare practice. These features are prominent in the descriptors of ethical sensitivity offered by authors such as Weaver (2007 & 2008), Rest (1986) and Milliken (2013).

Ability to identify ethical issues in a specific situation

As a feature of their developing ethical sensitivity, the participants were able to to identify key ethical issues within a given situation. This ability, stemmed both from being on a partner medical school programme and the contrasting experiencing that this offered, but also from their own personal biographies, including culture and religious beliefs and values.

The participants' exposure to various clinical practices and contexts stimulated their curiosity early in their medical education. One example of this was Nadia, who demonstrated her ability to identify ethical issues when she questioned observed behaviour early within her clinical experience. Nadia commented on the issues pertaining to medical students not seeking informed consent when treating patients.

She made various references (see p.109 and 111) to issues of consent (especially informed consent) and was particularly struck by her observations in which she had seen doctors not explaining risks of procedures to patients "when the patient could very well die on the (operating) table." Nadia commented with regards to her observations of the application of consent and confidentiality within two settings.

Nadia - obviously confidentiality, consent, comes in.. It's a big role in the UK but it's not so much in Malaysia. … I have seen doctors consenting patients, without like, to me, without even explaining properly to the patient what the procedure involves, what are the risks. I mean the patient might well die on the table, things like that. It needs to be communicated to the patient.

Nadia drew comparisons between her observations. She argued that procedures are not explained properly, thus demonstrating that such practices are not aligned with what she would consider to be best practice. She experienced a conflict between what she understood and how she was required to practice. In the above statement Nadia identified how, in the UK setting, consent and confidentiality form a big part of the patient consultation by way of the approach in which the consultation is conducted. She spoke about the differences in approach that she had observed in the two countries. In the extract below, she showed how she was able to identify issues of confidentiality within her experiences in a hospital clinic in Malaysia.

Nadia - Confidentiality is a main thing as well. I was once in what was meant to be an orthopaedic outpatient clinic. So, within the clinic there were 3 or maybe potentially… yes 3 doctors, so running a clinic simultaneously. So, there would be 3 different patients seeing 3 different doctors and then they were being examined without curtains being pulled or doors being closed.

Above Nadia provided a description of the busyness of the clinic, whilst other participants such as Samyyah (p. 145) commented on the volume of patients being seen, the available space within the clinical area and the impact that this had on maintaining the confidentiality of information. Naseem spoke of the patient "*having the authority to control all the information* (in the UK setting)", describing a difference in ethos with regards to how confidentiality is upheld and what the thresholds are.

However, the divulging of patient information was not always purposeful and does not therefore demonstrate the doctor's personal philosophy on the handling of personal patient information. Lian (p. 137) provided an example of doctors using mobile telephones to communicate results due to not having a bleep system in the hospital. The potential exists of divulging patient information by forwarding patient details to an incorrect number, yet this is due to the health system infrastructure and not the doctors' preferred practice. In addition, Samyyah (p. 135) spoke about how the structure of clinical areas made it impossible for doctors to stop patient information from being overheard by others. However, Nadia proposed that simple procedures, such as closing doors, would have aided in the protection of patient privacy and information. This did not happen, and therefore the patient's privacy was not protected, and confidentiality was breached. Throughout the discussions the participants demonstrated that irrespective of the context and circumstance they were able to identify ethical issues within a given clinical scenario.

ACCOUNT FOR PATIENT NEEDS

The above examples illustrate how the participants described incidences in which they had identified the ethical issues within healthcare practice being compromised or not exercised appropriately. In situations where ethical practice was evident, the participants were able to recognise this, including approaches such as sensitivity to patient needs and respecting patient choice. Whilst the participants provided context on how ethical principles were compromised due to external factors such as patient numbers or lack of resources, there were other occasions in which the needs of the patients impacted on how ethical approaches were exercised. Sarayah provided an example in which she had observed healthcare professionals provide care to patients without informed consent being explicitly obtained.

> *Sarayah – that's because they (the aborigines) don't live near, they live in the forest. So they don't go to the main city where the hospitals are.. So we have very near the hospital, and the forest, for them. So then the staff would go once a month or every two months into the forest to look for them and help them*

As was presented in chapter 5, Sarayah described an approach to care where consent was not overtly acquired, yet the tribespeople did not resist care (p.114). This suggests the tribespeople imply their consent to care through their actions. Sarayah also spoke of "helping them" but did not offer an explanation as to the health of this population. In circumstances where care is required urgently, informed consent can be overridden by the necessity of the situation. By using the term "helping them" Sarayah described a paternalistic approach to care and acting in the patients' best interests. She did not refer to consent being obtained from these patients, yet she did not illustrate that resistance to care was met when working with the tribespeople. The key point from Sarayah's account was that the obtaining of consent may be implicit due to a lack of resistance, which is therefore equal to consent being overtly obtained. However, in instances where the patient is seriously unwell, the need to treat them would override the need to obtain consent.

In the above example, Sarayah presented an example in which the best interest of the patient, in this case the need for health intervention, overrided the requirement for informed consent. There is a conflict in the ethical principles that underpin healthcare in this situation, hence a decision is required about which principle is given priority. This is not uncommon in healthcare practice and Sarayah highlighted the challenge of meeting both physical healthcare needs and need for autonomy. The following situations described by Alwi provide contrasting examples of approaches practitioners can take when patients are exposed:

Alwi – I mean in here (UK hospital) they (doctors) really, really ask. if the patient is a muslim woman they ask if they want a male student or a male doctor in the room. They really, really ask. In Malaysia they wouldn't. I don't know, maybe it's changed now, but probably not…

He added

.."come," that's how they (the doctors in Malaysia) would say it. If there is a student, "don't be shy" there's about 8 people in the labour room (in Malaysia)

Here, Alwi suggested that the medical team in the UK "really, really try" to find a female doctor to meet the needs of a Muslim pregnant woman, whereas he suggested that this would not be the case in Malaysia. Alwi demonstrated sensitivity towards the patient and their needs, especially with regards to optimising their dignity in this situation. This sensitivity for the patient denoted a degree of empathy and compassion on Alwi's behalf. Compassion is a personal emotion whereby there is an attempt to understand the emotional state of another person. Alwi drew on his understanding of Muslim beliefs in his observation of practice in UK and Malaysian settings. In his interview, Alwi presented a scenario whereby female patients are subjected to intimate examinations by male doctors, which he described as being a sensitive issue. Sarayah recalled a similar experience in which she observed that the patients' rights to privacy and dignity were not upheld. In an earlier discussion of this experience (Chapter 5 p.106) Sarayah illustrated that she considered this inappropriate.

> *Sarayah – We (the students) were brought through a door that goes straight through the labour room with many women giving birth .....*

Because of the differences in her experiences in two different healthcare systems, Sarayah was sensitive to features that are considered normal within a particular cultural context. For example, she was drawn to her observation of the labour ward in the UK she when observed women "get their own room with a bath-tub." As a solitary comment, this statement has little importance. However, in the context of the full extract it becomes evident how Sarayah was particularly sensitive to this feature of the clinical area and thus provides an example as to how the students' clinical experiences contributed to them being sensitised to issues in practice.

> Sarayah - *So we came through the door that brought us straight through the delivery room, and a few women were giving birth, and I saw a health. I don't know if he was a health attendant or a doctor, breaking water, and it was the first I saw and I thought "oohhh ok. I wasn't even at med school yet. And when I came here and I was on labour week, I saw the women get their own room with a bath-tub, and some can even have a water birth, so I thought "this is very different" It was a big change*

From these examples, it is evident these participants drew comparisons between their experiences of the delivery of healthcare in different settings in two different healthcare economies. The participants were challenged by their understanding of what they observed, and in some situations they were very clear about the appropriate decision and actions to be taken. Yet in other circumstances they were unclear about what need should take precedence over the other.

Ability to assess/interpret situations

Context was an important factor when assessing and intererpreting ethical practice within various situations. The participants demonstrated the need to adapt ethical practice to accommodate for cultural needs, issues of resources and patient numbers, alongside accounting for principles which override others and the situations in which these apply. Sarayah spoke about the following situation

Sarayah …they were talking about the DNAR and the prognosis in the corridor in front of the mobile computers, you know, where they can show the scans. I was in the corridor, and there was people walking in and out, and people walking past, through them. But the consultant himself was very nice to the family, but I think the situation was very busy and there was a gathering of people… physiotherapists, nurses.

As discussed in chapter 5 (p. 120) Sarayah was highlighting a situation whereby patient information was at risk of being disclosed to others outside of the immediate family and healthcare team, thus breaching patient confidentiality. However, Sarayah was able to assess and interpret the situation. She provided details of the context and an explanation that there is a need for a multi-disciplinary approach and family involvement in order to make a decision that is in the patient's best interests. This interpretation of the situation is very different from one that pointed to careless disregard for the privacy that is afforded to a patient's personal information. Sarayah highlighted that being "in front of the mobile computers" addresses the need to access computerised records such as scans and x-rays. Thus, the need for this equipment and the number of personnel involved restricted the setting in which these discussions could take place. Therefore, although Sarayah was able to identify the

ethical issue in this scenario, her description demonstrated that she was able to assess the appropriateness of these actions and offer a rationale for these decisions being an appropriate response to the clinical needs of the patient and urgency of the situation.

Consequences

The consequences discussed in the following section relate to what happens as a result of the participants having an understanding of the ethical dimensions of practice. These include; issues pertaining to what is considered acceptable within specific cultural contexts, particularly the expectations and needs of the patient, and understanding when and which principles to apply within a given situation.

Accounting for cultural context in clinical decision-making and care

In the previous discussion it is clear that the participants were able to identify different approaches to practice in various settings and, in some situations, decisions were based on the application of ethical principles and moral duties. These observations related to both the expectations of the patients, those of the health system and what is considered acceptable within these contexts. What was demonstrated from the participants' accounts was that there was not a correct way of approaching care, but that there was a number of alternative approaches to care delivery. These variations were dependent on the clinical/cultural contexts of each individual situation.

Interacting with patients within different contexts

Within the partner medical school programme, the participants were exposed to healthcare cultures with differences in their approaches to care. The participants not only experienced working with patients who had varying expectations of care but

also noted that the healthcare systems had expectations on how the patients should be cared for. Pei-Jing observed

Pei-Jing - because we were in IMU and we came here for 3rd year for practical and the surprise was that we had communication classes on our schedule and we had totally no idea whatsoever. We were never given any classes or group settings on how to communicate with patients. Ideas Concerns Expectations (ICE) were never taught at all. It wasn't anywhere in our book signage or lecture notes. Our focus in Malaysia is to know the disease, to know how to treat it and have a great knowledge base on the diseases, other than communication. Communication was, if there was any touch on communication, I would say it was about 5%.

Pei-Jing noticed a shift in the structure of the curriculum in her transition to the UK element of her course, from a disease focused curriculum to one that was patient-centred. She described how she was surprised at having communication skills within her timetable. Lutfi however, showed that he valued communication skills and illustrated how it formed part of the complexities of the doctor-patient interaction, beyond treating the physical aspects.

Lutfi - but I think it's more than that, it's a complex thing, to have the "soft" skills, the skills around it, with the knowledge of medicine, "give this medication, go home". But because you are treating a human, it's not as straightforward as that, and when you talk to them, it's not as simple as that. It's the small bits that people overlook, which many people back home overlook, which they didn't care. "Got a problem, give this medicine and be done with it". But, the soft skills, the communication bit, treating them like a human being, and the medication bit the surgical bit as well. I learn a lot

Lutfi described additional skills, "the soft skills," that he was developing in the latter part of his programme. He used the phrase, "treating them like a human." Lutfi was referring here to the need to demonstrate compassion within a patient consultation as humanity is utilised by Crowther (2013) when speaking about what constitutes compassion. Lutfi spoke about soft skills that are involved in the patient-doctor interaction, with soft skills often considered to be personal attributes that enable a person to engage with others and include empathy and listening skills (Van Staden

et al. 2006). In the phrase "got a problem, give this medicine and be done with it", Lutfi related to a lack of caring, as in this statement he highlighted a disease-focused approach, with no understanding for the patient's "problem" (or condition). An attempt to understand the patient's struggles would denote a degree of concern for that individual and, through showing concern, compassion would be achieved. Therefore, Lutfi was referring to the need to demonstrate compassion within a patient consultation through virtues such as care and concern, and that this would enhance the patient-doctor relationship. Overall, Lutfi appeared to be struck by these "soft skills" and showed how he appreciated the importance of these as part of a patient's consultation.

His final sentence in this extract indicated that he is enhancing his knowledge and skills as he spoke that he has "learnt a lot" with regards to incorporating all aspects of care. These include treating the physical aspects as well all those needs attributed to the human nature of the patient, such as compassion. However, the participants also accounted for alternative approaches to care based on the cultural expectations of the patient population. All the participants spoke of issues pertaining to confidentiality and highlighted their understanding of cultural differences in approaches to confidentiality and sharing of information. Naseem observed the following

> *Naseem - The difference probably when it comes to confidentiality that's what I think. Back in Malaysia this confidentiality.. they still do confidentiality but maybe not as sensitive as here (UK)….. Here (uk) the patient has authority to control all the information.*

With Pei-Jing adding

> *… the difference in culture is that in Malaysia it is more of a family setting, that everyone shares everything, even with friends, so any medical conditions they would know. If an elderly, if my grandma were to go in, everyone would know what is happening. The doctor wouldn't ask my grandma "is it ok to show your relatives about what is going on"… it is an unsaid agreement that you can tell whoever.*

The participants demonstrated their appreciation of a number of issues. They spoke of the differences in adhering to confidentiality and sharing information between countries. However, Naseem spoke of how the patient's position in the UK is different as they have "control" over who their information can be shared with, thus alluding to a patient-centred approach to care. Yet, this is a simplistic perception of how patient confidentiality is maintained. For example, in the care of adults, exceptions exist dependent on capacity, issues of safeguarding themselves or the safety of the wider population. Naseem also identified issues of confidentiality in more complex situations such as paediatrics, and observed how in the UK the sharing of information with parents was not absolute, in contrast to his experiences of Malaysia. However, Naseem did not illustrate the factors associated with sharing information with parents, and how these influence how and when this sharing or withholding of information occurs.

Pei-Jing described that in Malaysian culture sharing information with relatives without acquiring patient consent is an accepted practice. However, in earlier discussions, it has been presented that Malaysia has a family-centred approach to care, with relatives assuming a great deal of responsibility for older family members based on the level of respect given to senior family members as part of their culture. The participants here were not critical of how patient information is handled but were demonstrating that they are knowledgeable of the different practices and aware of expectations within each national setting. Although they observed the differences in practices, their discussions were limited in their observations or experiences of when the patients' control over the sharing of their information was not applicable. The sharing of information with family members, carers and outside agencies is complex. However, participants did not share experiences of having observed incidences in the UK setting when these exceptions to maintaining confidentiality applied. Thus their lack of experience in encountering complex cases may have resulted in how they perceived confidentiality was maintained within the different cultural contexts.

Culture and compassion

Compassion was identified as a feature of enhanced ethical sensitivity that emerged from the analysis of the interview transcripts in chapter 5. The Oxford dictionary

defines compassion as a list of qualities which include, pity, sympathy, understanding, care, concern, warmth, humanity, tolerance, sensitivity, benevolence and charity to name a few. According to Crowther et al. (2013), "Compassion is a deep and personal emotion and is defined as the ability to understand the emotional state of another person…" It is a much stronger feeling and urges one person to do something to alleviate or reduce the suffering of another (p.492). Other authors such as Gilbert & Choden (2013 cited in Folaki 2015:199) argue that the term compassion can be defined as "the sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it" and, although it is not the same as empathy, both terms are closely related. Empathy forms part of compassion as the essence of empathy is to understand another's feelings or experiences by trying to place oneself in another's shoes. According to the definitions of both Crowther et al. (2013) and Gilbert & Choden (2013), compassion goes further than simply understanding a person's suffering but aims to alleviate, reduce or even prevent it.

In chapter 5 (see p. 142), Lutfi described a situation whereby patients were receiving intimate examinations in close proximity of each other and female patients were being examined by male physicians without a chaperone present.

> *Lutfi - ….we needed to do a PR exam, and if they were happy for me to do it, as there was another patient present in the same room. Yeh, so it was a bit…. And there was no chaperone at all. When I encountered that problem, I thought "it shouldn't be like that" and I didn't know what I should do.*

In that situation Lutfi stated that "it shouldn't be like that" and that "I didn't know what I should do." This statement has various meanings. Upon first reading, Lutfi appeared to be describing that he didn't know what he should do by way of proceeding with the examination or not. But his statement also conveyed that he wants to do more to alleviate this situation for the patient. With reference to the definition of compassion by Gilbert & Choden (2013), Lutfi was seeking to alleviate and prevent this situation which he felt was inappropriate. With regards to this situation he added that he "didn't feel comfortable" with the situation, suggesting that he was sensitive to the patient's needs and possible suffering in this case.

In addition, Guan-Yin also spoke of her experiences when seeing patients being offered end-of-life care. On p. 149, she noted that she was surprised at the fact that care was offered to patients who were dying.

> *Guan-Yin - I think that it is very good. It's fantastic, even if you have cancer, you are still dying, but we still care for you. They still provide you something, rather than in Malaysia… I don't know how but I just think that we don't have these kinds of things.*

Guan-Yin's statement suggested a degree of surprise that care is provided in cases of terminal cancer. Here she was acknowledging that although from a curative perspective there was little to offer the patient, there was still a drive to relieve or reduce suffering, even though they were unable to prevent it. Guan-Ying drew a comparison between the two countries but didn't elaborate on what is available in Malaysia.

Jia (p.147) spoke about the disease-focused approach she had observed. When speaking of breaking bad news to patients she stated

> *You can just tell the patient and of course they will think they will definitely be sad, but it is not really my (the doctor's) job to care if the patient is sad or not. That is probably for the family*

With reference to the definition of compassion, this statement illustrated a lack of empathy for the patient's feelings. Moreover, her statement showed little responsibility on the doctor's part to attempt to reduce or prevent suffering caused by the delivery of difficult news. The role of the family in this situation would suggest that physicians do not have the need to be compassionate and to attempt to minimise the impact that distressing news may cause. However, in the discussions of the role and responsibilities of the family in Malaysian culture, none of the participants reported how the family was supported when providing care and support for their loved ones. Thus, although the family are responsible for the offering care and compassion, there was little evidence of attempts to reduce the suffering of the family.

Expectations of acceptable healthcare practice

Acceptable behaviours of staff and patients within the various cultural contexts varied and the participants identified these throughout their interviews. They did not always agree with the practices they observed, yet they put their observations into context. Eu-Meh provided an alternative perspective on what is considered acceptable behaviour*.*

> *Eu-Meh - when I went back home for my elective, the ethics of how doctors how they treat the patients is very different from here…. So we have to treat them (patients) equally, because I've been here, it really feels that in Malaysia the doctors aren't treating the patients very equally, because you can see the difference from one bed to another. If in the bed there is a well-educated, well-kept patient, as opposed to an immigrant who are not well kept, who are very poor, quite dirty, the way the doctors act are totally different. And the time spent with the patient is lesser. So from there it makes me feel like it shouldn't be like that. As a doctor you should treat everyone equally no matter where they come from and how poor they are*

Eu-Meh, demonstrated her understanding of the duty of a doctor to treat a patient based on their level of need, not their social status or class i.e. treating the patient fairly. However, Eu-Meh drew a comparison between two systems and discussed her perceptions of how doctors within the clinical setting in the UK treat patients with more equality than in Malaysia i.e. not based on socio-economic status. However, there are reports in the UK, such as the Understanding Inequalities in Health (Connolly et al 2017), that clearly state that this is not always the case. There is existing discrimination in health service provision to people with learning disabilities (Glover 2018) and lower socioeconomic status (Connolly et al 2017). However, this was Eu-Meh's interpretation of her observations in practice. The point here is not whether doctors are treating patients fairly, through offering equal opportunities to care and respecting their rights as patients or otherwise, but more so the participants' ability to identify distinct practices between healthcare environments, and as a consequence enhance their understanding and sensitivity to ethical issues. This understanding does however enable the participants to consider alternative ways in which to approach patients. Across the interviews, there did not appear to be a consensus about adopting one particular alternative approach. Alwi and Kueng

spoke of the concept of "doing no harm" as being a fundamental feature of patient care.

Alwi - as long as I don't do any harms, then its ok

Alwi - Even myself, I accept what the doctor tells me, it's not going to do any harm to me..

Alwi - you're sure it's not going to harm the patient and the patient will follow whatever they've been told.

The principles of doing good and doing no harm are both key features of the 4 principles of healthcare approach according to Beauchamp and Childress (1994) often referred to as beneficence and non-maleficence. Although, neither Kueng (see p. 150) or Alwi used this terminology, their statements demonstrate their understanding of how these principles are applied in clinical settings. From Alwi's perspective, it appeared that doing no harm is an overriding factor in patient care.

The accounts shared by Nadia and Sarayah upon recalling their experiences on a clinical placement with the Aboriginal tribes in the Malaysian jungle (p.113-115) offered an approach which appeared to negate the dimensions of consent, dignity, privacy and autonomy. The participants commented that "the patients didn't know why they were in the hospital" and that "staff went into the jungle and took them into the clinic." However, it could be argued that these experiences were illustrative of the overriding intention to act in the patients' best interests. This approach also demonstrated that it met the needs of the patients not simply from a medical perspective. Ibrah spoke of how there were provisions made for the Aboriginal patients to have their families stay with them in hospital. This is in keeping with the Malaysian ethos of a family-centred approach. Nadia also referred to "these people were walking around with no clothes on in the hospital." Although this observation struck Nadia as an abnormal feature, it again reflected that patients were able to behave within their norms when taken out of their home environment. Therefore,

although this approach is not what would be conventionally referred to as a patient-centred approach due to the lack of autonomy and consent in seeking healthcare, it does offer many features of fulfilling the patients' needs on levels other than the biomedical. In this example, patient autonomy is overridden by the principle of beneficence, as the medical staff are acting in the patient's best interests. This is a common practice across healthcare whereby, in the absence of capacity and consent, the needs of the patient would be paramount. However, the overriding of autonomy is contextual. Patients may decline treatment or make choices that may seem unwise and not in their best interests. However, treatment cannot be imposed on them simply because physicians disagree with their decisions. What is considered to be an unwise choice is nonetheless an autonomous choice. Yet, enabling a patient to exercise their autonomy can in itself be of benefit to the patient, allowing them to make decisions and exercise control over their situation.

Expectations of what is considered to be acceptable practice varies between cultural contexts. In her interview, Nadia shared an experience that demonstrated the differences in attitudes from both staff and patients towards their expectations. Nadia drew a comparison between both clinical areas (UK and Malaysia) in order to contextualise the doctors' approach.

Nadia - Sometimes over here (UK), consultants will say "oh we've got 20 patients before we finish the clinic." You can imagine in Malaysia a consultant will end up seeing 40 or 50 patients in one session. They just have, to cope with it, like you just have, to do it. Whereas patients here get a full 10-20minutes consultation when they come, so I guess that makes a difference. Over there, it's like 10 minutes at most, maximum. And patients won't get the opportunity to ask questions, the doctor will be saying "you have this, you have that, that is the treatment" It's like that. … And the doctors don't invite questions as well. You know like here (UK), after the consultation, they ask "oh do you have any questions for me. Have I been clear so far?" There's no room for that pretty much

Researcher - and the patients accept it?

Nadia - that is probably normal for them

Nadia concluded that in the UK, there is more time for doctors to invite questions from the patients, though she also acknowledged that the clinicians in the UK feel under pressure when seeing up to 20 patients in a clinic, thus illustrating what these clinicians expect from their workload. Nadia's perception of practitioners in the UK having more time is based on her observation of practice in Malaysia. Thus, for her, what is referred to as a "busy clinic" differs a result of the range of alternative experiences she has had. However, although Nadia referred to the time constraints and workload that the Malaysian doctors face, in her last statement she added a sense of this being a culturally-accepted norm for the patient.

Remaining on the subject of culture, other elements could be considered as impacting the doctor-patient interaction. Some participants, such as Lutfi and Pei-Jing, discussed the way that care in Malaysia is disease-focused, whereas in their UK clinical experiences there is consideration that the disease has both a biological or physiological aetiology and also psychosocial elements which must be accounted for. Thus, Nadia illustrated practical factors that impact on the application of the ethical dimensions of practice, but also showed a level of cultural sensitivity, as she was not being critical of either system but understanding that as an institution each healthcare system has its own culture. Culture is an issue that surfaced throughout all interviews and the analysis in the previous chapters has discussed this at length. However, as previously discussed, although the participants questioned and challenged the practices that they have observed, they did balance the overall observation by demonstrating an appreciation of the cultural needs and expectations of the society they were working within.

Cognitive anxiety

The participants spoke about experiences that led to them experiencing uncertainty in situations which led them to feel uncomfortable and unsure of what to do. Lutfi's illustrated this when he was uncertain as to whether he should examine a patient in a clinical environment that did not preserve the patient's privacy and dignity, but where the patient still required access to care (p. 141). The participants also discussed the discrepancy and conflict that they experienced between their values and beliefs, the

theoretical knowledge that they acquired and their observation of practice. They were often uncertain about the right behaviour and the most appropriate decision in a given situation.

Fazey & Hardy (1988) describe cognitive anxiety as negative concerns and self-doubt about performance, with Woodman &Hardy (2003:441) defining it as "negative expectations and cognitive concerns about oneself, the situation at hand, and potential consequences." Other authors such as Stenling et al. (2014) speak of cognitive anxiety in relation to achieving set goals. Failing to obtain a goal would negatively influence a person's cognitive anxiety, with the opposite being true if goals are achieved. However, they suggest that goal setting is an important factor for individuals who strive to perform. This was evident in the participants' discussions. Alwi shared his concern as to how to address the issue of delivering bad news to a patient. He spoke of having observed and been advised on how best to approach it, but still felt uncertain on what he should do.

> *Alwi… the issue that I'm not .. that I'm struggling with ok? Is how do you Break Bad News? Some people say you should get someone in charge. Others say you should just say it directly, don't beat around the bush. My approach, because of the way I am, is just say it, but some people don't. They say it depends on the patients and whether they want a bit of a slow build up to the news and not to say it directly. My problem is, I don't know which one patient wants whether it is a direct shot or a build-up shot… Yes, its confusing…*

Alwi demonstrated that he has his own approach on how he would prefer to address this situation, but he questioned his ability to interact with a patient and ascertain their needs and wishes. Alwi showed that he has knowledge of how to deal with this situation at this stage in his professional development but he was still confused as to the best practices in the delivering of delicate information to patients. Alwi demonstrated that he has some self-doubt, and this stemmed from his confusion about the varying practices and deliberations over what would be the correct course of action. In his interview, Alwi made reference to his approach being one that would be considered usual practice in Malysia. This approach by doctors was also referred to by other participants, such as Jia (p. 147), who had stated that the patients' emotional wellbeing was not considered as part of the

doctors' role. Thus, Alwi's statement above, and the accounts he shared in Chapter 5 (p. 116 p. 124, p. 125) where he makes distinctions between the clinical areas in the UK and Malaysia, suggest that these differences that he had encountered in the different cultural contexts impacted on his confusion and uncertainty as to what would be the most appropriate course of action within the various clinical scenarios.

Figure 5 (below) provides a diagrammatic representation of the element of cognitive anxiety and its associated antecedents, attributes and consequences.

Figure 5 – the antecedents, attributes and consequences of cognitive anxiety
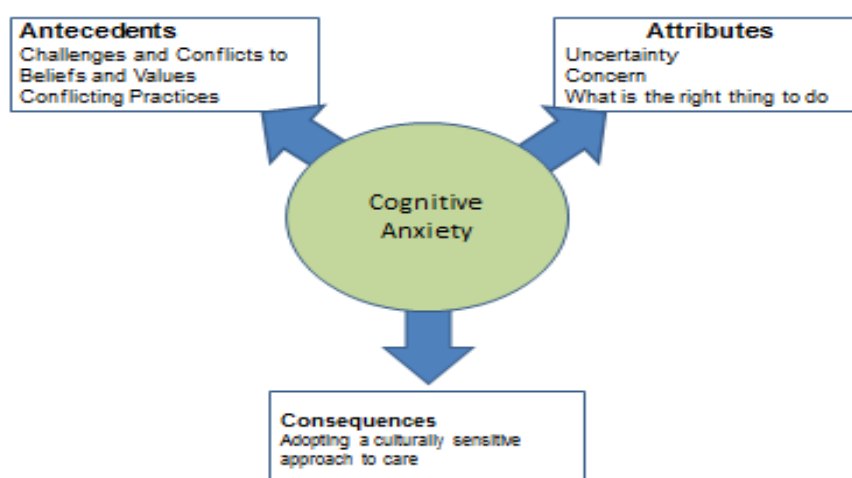
Antecedents

Earlier in this chapter, the participants' experiences in different clinical settings were discussed. Clinical experience continues to play a role within this discussion of how the challenge to the participants' personal beliefs and values, their existing level of

knowledge and their experience of contrasting practices are the antecedents of cognitive anxiety.

Challenges and conflicts to beliefs and values

The participants described some of the beliefs and values that they held prior to entering the medical programme, and how beliefs about healthcare practice through their education and clinical experiences influenced those beliefs and values. The participants spoke of how in Malaysia (and Asia) there was a strong trust in the medical profession. Hai commented on how the patients "trust the doctor 100%" and Ibrah's outlined how patients can regard doctors "as God." Other participants suggested that doctors are trusted to act in the patient's best interests and do them no harm, as illustrated on p. 125 by Alwi. The participants came to learn in an environment in which the patients are encouraged to question and challenge decisions and form a partnership in care with the doctor, but they also experienced a clinical setting in which the opposite of this was true. This challenged beliefs and practices they may have grown up with and learnt during their early years and many of them spoke of being unprepared for this. Values and beliefs are part of the participants' sense of being and to have these challenged can create an ambiguity and uncertainty as to what is the right course of action when there are options with various outcomes.

Conflict of values and beliefs

The participants referred to conflict that they had experienced when in clinical practice. Conflict often existed between experiences they considered to be best practice and their perceptions of appropriate behaviour based on their experiences during practice placements. One example of conflicting beliefs was provided by Alwi. Throughout his interview, Alwi suggested that he enjoyed the scientific aspects of medicine, such as learning about the body and diseases. He suggested that professionals can know best and patients should accept their diagnosis and treatment.

Alwi -But people in my surrounding, they just accept it so, they don't have like, involvement in the decision making process, they just accept it (laughs) Yeh, that's it. Even myself, I accept what the doctor tells me, its not going to do any harm to me. I mean… Here (UK) they… they, the patient makes a decision on what they want and of course I'm surprised. Basically, what I think, not what I've been taught, but what I've been brought up, if you can't take advice from people who know better than you…

In the above, Alwi even referred to his own acceptance of what the doctor is advising. He stated that the doctor is not going to harm him, alluding to a great sense of trust. Alwi claimed to have been surprised by how in the UK the patient can make decisions, and he questioned the logic behind seeing a professional if one then chooses not to heed their advice. However, when relating to his own future practice, Alwi spoke of moving away from the disease-focused approach that he was so strongly in favour of throughout the interview.

Alwi - But I think, I should have a nice approach to the patient, really, really looking after her, not looking after the disease, and look after the patient, which is appropriate to do, which is what I think.

Alwi had described his observations of doctors who adopted a task-focused approach to patient care, which arguably would be a disregard for patient consent and dignity as evidenced in his labour ward experience, and experiences where patient consent and choice was upheld. However, Alwi appeared to contextualise these experiences in order account for inconsistencies.

With regards to his labour ward experiences as presented on p. 124, Alwi felt that especially in light of the female patient's religion, there should have been a degree of respect to reduce exposure to male doctors. Yet, he did allude to the fact the necessity of an emergency situation would override the issue of wanting a female doctor, as the aim would be to minimise harm to the patient. By speaking of people "in his surrounding" he demonstrated an acceptance that patients will have different expectations which are dependent on the cultural context. At the end of his interview Alwi commented that he could not promise to utilise all the patient-centred skills he

had been taught and stated that he was aware that time and other factors would affect his decisions. But his final compromise was to do his best for his patients.

Alwi - But it depends sometimes, there is external factors, can't really name them, but it will probably change my judgement I mean, that's, that's , I'll try my best to do everything that is appropriate to do for the patient.

Alwi did not elaborate on what he meant by the statement "do everything that is appropriate…" but, from his interview, Alwi had clarified that his overall aim was to do no harm. Thus, with reference to Stenling's (2015) definition of cognitive anxiety and its links to objective setting, for Alwi, his prime objective for practice was to ensure that the principle of non-maleficence (to do no harm) was upheld.

Ideological challenges

Challenges to ideology relate to the experiences of the participants with regards to their theoretical knowledge not meeting the reality of practice, personal values and beliefs and the application of such factors to the decision-making process. Thus, in order to accurately represent this underlying discord between theoretical knowledge and personal values and beliefs and the reality of practice, the term "ideological challenges" was considered more suitable than simply utilising "theory-practice gap." Earlier examples, such as those presented by Sarayah (p. 120), discussed how participants observed a situation whereby a patient's details were being discussed and bad news was being communicated to the family in a public ward area. This conflicted with what Sarayah had been taught with regards to patient confidentiality and breaking bad news. Jia, in her interview, commented she had not always observed consultants in the clinical area applying the skills which she had been taught in the classroom. When discussing observing the skills taught in the classroom Jia stated

Jia - I guess in a way… not fully. There is some form of something (of skills) there. They are quite… they are actually…. like they genuinely do care and treat the patient

nicely as well. I think its common to treat people like you want to be treated.. I think it's quite good that they do follow that (framework). Its not completely 100%, but I guess they are busy as well

Jia spoke of observing some of the skills that she been taught in the classroom being used in the clinical area. She referred to clinicians being busy as a rationale for not being able to fully apply these techniques in practice. She spoke about the kindness shown to patients by the doctors she observed, but attributed this to simple human nature of treating people in a manner in which one would like to be treated, and not the application of theoretical knowledge. However, she commented on how she found learning to use these skills useful

Jia - Yes I think it (the teaching) has helped. Sessions like the communication sessions, and I think it's quite useful and helpful as well, and a lot of experience on the wards as well.

Jia showed positive affirmation of the benefits of engaging with the learning she had had. She continued to discuss the application of these skills in her own future practice.

Jia I think I will definitely try (to use these skills), I think it's the right way to treat patients this way. So I will definitely, you know, use stuff. Hopefully it's alright, I guess.

Jia showed elements of doubt as to the applicability of these skills. She spoke of believing in what the correct way to treat patients was but demonstrated a level of uncertainty by saying that she hopes "it's alright." This last phrase indicated a level of worry. Although Jia appeared positive about utilising the skills and frameworks she had acquired, she did not appear to be confident about using these in her own practice, as she spoke of not having seen doctors using these skills fully in her experience of clinical practice.

Expectation-reality gap and cognitive concerns

This term concerns the differences between the expected and experienced reality. It relates to the difference between the participants' expectations and thoughts of what the reality of their encounters in practice should be, based on their own experiences of their cultural and social norms and what the actual reality has been for them. This is not a gap which has a grounding in taught theory, but instead is based on their expectations as drawn from their understanding of the world around them.

Nadia provided an example of both theory-practice and expectations gap. She demonstrated this uncertainty in her observations of a hospital in the Malaysian jungle which cared for the indigenous population.

> *Nadia - So, these were the Aborigine in Malaysia. So, then we went there, they don't speak Malay, so they speak in their own language as well. We can see its completely different like, they can walk around the entire hospital without wearing clothes, but that is normal to them, and some of them don't even know why they are there.*

Nadia spoke of how not wearing clothes is "normal" to these patients. Here Nadia was raising several points. She spoke firstly of how these individuals speak in their own language and don't speak Malay. Nadia previously highlighted her struggle with communicating with patients in Malay, but in her statement she demonstrated that in this setting language and communication were a challenge for others too. She does not support this by speaking about specific communication issues, such as gaining consent from the patients as she had previously stated, but she does comment on how some of the patients did not know the reason for attending hospital. This therefore indicated that consent was not gained from the patients and thus alluded to the possibility that the differences in language could have been a factor. Nadia previously demonstrated her knowledge of consent and the differences she has noted in both Malaysia and the UK. The above experience was prior to Nadia's registration with a UK medical school and learning about patient consent within the programme. However, Nadia's comments suggested that she believed in the need to obtain informed consent from the patients prior to interacting and treating them. The dissonance that exists is due to her experiences where patients are admitted and

treated in hospital without being fully consented for this. In this scenario, Nadia displayed concern for patient dignity as she spoke about the nudity exhibited by the patients in this hospital. She commented on how this was "different", which implied that this experience did not conform to her expectations of patient behaviour in the clinical area. This patient behaviour in itself posed a challenge to her, but she may also have questioned why the patients' dignity was not being protected by the staff, as her prior understanding was to optimise patient privacy and dignity.

However, in this scenario, nudity may not have been undignified for the patients as it was a cultural norm for them, as reflected by Nadia when she stated that this was "normal for them." Nadia was able to contextualise this, although this was outside the realms of what was comfortable for her. To enforce the wearing of clothes could be considered an infringement of their liberty. Nadia had stated that some of them didn't know why they were in the hospital, therefore to further enforce changes to their normal way of life may have been deemed as more undignified through having outside values and norms imposed on them. Nudity creates exposure and vulnerability, placing patients in a position of possible exploitation and creating an imbalance of power between them and their carers, which could result in barriers between the doctors/nurses and the tribespeople due to the obvious differences. Yet, Nadia did not speak of the doctors feeling uncomfortable in this situation and the nudity of the tribe was not referred to by other participants who had had a placement in this hospital. Therefore, the cognitive concerns are based on Nadia's personal background and expectations of what she considered to be normal within these circumstances.

Nadia's previous knowledge and perception of maintaining patient dignity was reflected in her other comments whereby she demonstrated her disapproval of patient consultations in which curtains are not drawn or doors closed.

Nadia - So there would be 3 different patients seeing 3 different doctors and then they were being examined without curtains being pulled or doors being closed. Anyone could just come in and interrupt "oh doctor could you just check this x-ray out for me" and yeah. And they had about 10 or 12 medical students watching.

However, she showed that although this was not the approach she was familiar with, she did appreciate that this was an acceptable behaviour or lifestyle for these individuals. Experiences such as these support the participants to develop a nuanced understanding of the context where medical practice is applied. However, for Nadia this resulted in a process whereby she juggled her own beliefs about privacy and dignity, which differed to that of what she was experiencing. Yet another aspect is that the participants viewed their role as being an advocate, which involves protecting a patient's dignity. Therefore, in Nadia's example, acting in the patient's best interests and respecting their autonomy was brought into direct conflict with her beliefs about protecting patients' dignity. However, this challenging of her beliefs would aid Nadia's understanding of how patient needs and choices may undermine what would be considered social norms and allow her to develop in a manner that will enable her to make appropriate decisions within such settings.

Conflicting practices

Due to the array of practices that the participants were exposed to, they often found that clinical practices differed between the clinical settings. The process of attaining informed consent caused the participants some conflict when they observed variations in practices. In chapter 5 (p. 110), Alwi's description of consent procedures in Malaysia indicated that treatment options could be presented to patients in a way that limited their choice:

> *Alwi -Apparently, in hospital you can have consent but they (the doctors) try to give the patient the idea that you have to do that (have a procedure done)*

When Alwi learnt that "everything is consented" (in the UK), and patients should be fully informed of all details relating to the treatment and alternative treatments, this led him to reflect on the practice that he should adopt in his own professional practice. Similarly, Sarayah observed different practices for the acquisition of consent for a procedure from a patient:

Sarayah - You have to take consent for a PR exam (laughs) or endoscopy, because it is a more specific procedure. But here the consent and the privacy is more heavily… it is more important here! (UK)……

She added

They didn't ask consent from these mothers, they didn't ask these mothers. I don't know if its because it was a 3rd class ward I don't know.. at the time I didn't know anything of the health industry. So.. I guess that consent and privacy is not that important in Malaysia.

Sarayah illuminated the differences she had observed in the UK and Malaysia. She attributed the different approaches to what is acceptable practice within a country. Indeed, her discussion of consent in the Malaysian maternity service included comments about the social class and the gender of participants. These topics were not discussed in the UK context and she suggested that the focus was on ensuring that patients have understanding of the procedure.

Sarayah's final comment on this experience was "I do not want to give birth here", demonstrating her personal choice to be cared for in an environment that upholds a patient's right to consent. For her, conflict and anxiety lay in the fact that her personal values were not upheld and that she was witnessing others being treated in a manner that she would find unacceptable. Alwi shared a similar experience within the same clinical area, in which he too depicted a situation where a mother was not asked to consent to procedures and being observed by a number of students in a situation in which he had felt disrespected the patient's religious values. What these accounts highlighted is the lack of equality in how patients were treated in similar situations across different contexts. Sarayah spoke of women from a 3rd-class ward, whilst Eu-Meh commented (p.141) on how she had noted that patients who appeared to be from deprived backgrounds were not treated in the same manner as other patients. The participants experienced state-run hospitals in both countries. They noted how differences in equality existed, observing how within one cultural context choices and treatments were offered to patients based on their socioeconomic status/class. The participants felt conflicted as they believed that all patients should be treated equally, allowing for autonomy across all patients and not those from more privileged backgrounds.

Attributes

The attributes of cognitive anxiety were derived from the participants' need to contextualise actions and behaviour in relation to the setting they were in. The issue of context, together with factors such as uncertainty and challenges to ideology, provided an added challenge for the participants when assessing how others applied the ethical dimensions of practice in clinical practice, resulting in a questioning of the appropriateness of how ethical dimensions such as consent and confidentiality were upheld in practice.

Uncertainty of future ability to maintain ethical standards in clinical practice

The participants observed a myriad of behaviours, allowing them to identify areas of practice in which they questioned the clinicians' approach. Yet, the participants came to the realisation that working within a system that bases itself on particular beliefs and behaviours could result in them emulating these, often as part of belonging to a team. The extract below shows Lutfi' view

> *Lutfi - I think we should practice what's in the text book thing, what we should do, and then on the wards people are doing this. Its good practice, we should practice this at home as well, why not. I've heard complaints from past students, who have been in the UK going back to Malaysia saying "Let's do something, Let's, do a change and then THEY change into THEM. But it's not one person, it's not a one man show. It should be a group, or a consultant or head of department, who should set the example…It's the culture. When things have become so culturally integrated, it's a headache, because you have seen something else, and you think, why not, we have seen some good things that than be practised at home.*

In this extract, Lutfi stated that he has observed behaviours in practice that reflected theoretical knowledge taught during his studies in the UK. However, he indicated that he was frustrated when he believed that it would be difficult for him to alter such

behaviours, with the possibility of insteas reverting the characteristic practices he was attempting to challenge in a different context. Lutfi noted that junior doctors become the very people whose actions they criticise. However, the above extract suggests that should Lutfi he practice what he has learnt, he would face criticism, thus alluding to the fact that it would not be deemed appropriate behaviour in that clinical environment. Thus, the participants appeared able to distinguish which behaviours would be applicable to each environment, but nonetheless this appeared to cause internal conflict when they experienced tension between different values.

Eu-Meh shared a similar uncertainty with regards her future practice. She stated

> *Eu-Meh -As a doctor you should treat everyone equally no matter where they come from and how poor they are. It's like "it's not my concern, as long as we treat you and you manage to recover from your disease or illness or whatever." And yeah, it really puts me in a way that… Wow ok, errm I hope I won't be like that in the future (laughs) if I mingle with them*

Eu-Meh's final line in this extract captured her feelings of her concerns about working within a clinical environment which doesn't share her values on patient care. This uncertainty in her future practice occurred as a result of working within the two distinct environments. Eu-Meh also demonstrated an insight into future cognitive anxiety as she perceived the possibility of working in an environment that will challenge her beliefs and values. In so doing she demonstrated an enhanced understanding of what her reality could be as a member of the workforce within a specific clinical setting.

CONCERN

The participants showed concern in a variety of circumstances. At times, concern was related to the behaviours that they observed, but it was also about the wellbeing of the patients and the upholding of the ethical dimensions of practice, such as privacy and dignity and consent. Alwi (see p. 124) and Sarayah (see p. 143) demonstrated this in their observation of labour ward practices. Lutfi and Liwei also spoke of feeling uncomfortable when expressing concern about performing intimate

exams in an open clinical setting that did not offer patients any privacy. The extract from Lutfi's interview (see p. 140) presented an example of a situation where common practices challenged his personal beliefs and views on what he considered to be the correct action

Lutfi – and there was only one examination couch with a curtain so patient came in and I needed to do a PR exam(….)

In this example (see p.141), Lutfi was clearly uneasy about this situation. He was aware the physical environment of the clinical area was compromising the patients' privacy and dignity. Communication issues complicated the acquisition of informed consent. He refersred to the patient as "she" but did not elaborate on whether it was acceptable for a male doctor to examine a female patient, although he did acknowledge that there was not a chaperone. This suggests that he is aware that chaperones accompany patients in some situations and in these circumstances, and that he would have preferred to have one present. He clarified whether to continue with the procedure with one of the junior doctors, which indicated that he was uncertain about what to do in this situation. However, his attempt to act as the patient's advocate, because he was aware that there were ethical concerns about the procedure in this context, was thwarted. Completing the procedure did not reduce his concerns about the circumstances where this was conducted. Liwei shared a similar experience.

Liwei - me and a few of my friends from Malaysia we were discussing about this. You know we are from Malaysia, because we started our clinical practice here. We were not used to this… we found it quite uncomfortable, especially to have so many patients in one small clinic. And because as a student, there are 3 doctors and 3 patients, and there are 6 chairs occupied, so I have to stand in the corner observing. And then, when the patients want to go in, it is very crowded, the clinic room

Liwei stated that he and his colleagues found the experience of having numerous patients in a small clinic quite uncomfortable. He described how they were not used to this type of environment. Liwei's comment, regarding him standing in the corner of a crowded room observing the patient consultation, also added to the feelings of

discomfort for encroaching on the patients' privacy, as well as being an intimidating situation for the patient by having so many other people there.

The participants' concerns towards the lack of maintaining patients' dignity and privacy made them feel uncomfortable. This feeling was due to their personal constructs, particularly respecting patients' dignity and privacy, being challenged. Cognitive anxiety therefore arose, as the participants evaluated the utility of these constructs in working within this environment. Thus, the participants reached a point at which they realised that they were unable to anticipate the course that a given situation would take based on their existing constructs, thus leading to cognitive anxiety.

Concern as to the right thing to do?

Concerns led to the participants questioning what the right course of action to take in specific circumstances was. From all their experiences, the participants gained knowledge on the various approaches to care. However, at times there were discrepancies in how the ethical dimensions were upheld in practice.

Observations of both confidentiality and consent gave rise to uncertainty within the participants, and were mostly due to the differences the participants encountered between the UK and Malaysian settings. At times, experiences contributed to the participants being uncertain of how and when to apply ethical principles. This was often due to conflicts in the participants' understanding of the appropriate course of action or decision within a given situation.

Confidentiality was a theme prevalent in all interviews and one which demonstrated how the participants developed their understanding throughout their time on the partner medical programme. Kueng spoke about his early years on the course, where confidentiality was not an aspect of ethical practice that was stressed.

Kueng - I've not had plenty of experience with regards to confidentiality back home. Basically, because I was doing my pre-clinicals in Malaysia as well, how they approach the confidentiality issue during clinical years. But during pre-clinical years, I don't think that they have ever stressed confidentiality. Err maybe once or twice but not many that I can recall

Kueng spoke of how he didn't know how to approach the issue of confidentiality when in the clinical area as this was not something he had been taught previously. Sarayah (p.134) had also shown that she was uncertain of what her actions in managing confidential information should be. Sarayah elaborated further and provided insight into her uncertainty in understanding the boundaries of confidentiality based on her personal expectations as a patient.

Sarayah - As a patient in Malaysia, I don't have that expectation of confidentiality. I don't mind… I don't mind if the doctor's daughter is in the same school as me and he says " do you know that your friend has a cough? Because she had a cough this morning" I wouldn't mind that because I wasn't… I wasn't expecting it to be confidential, it didn't even cross my mind. but unless it's a secret thing, then I might say to the doctor "please don't tell anyone" it's a different thing, please don't tell anyone I don't want my family around. I think that's how most people think.

Here, Sarayah stated how her initial perceptions and understanding of confidentiality gave rise to her questioning the stance to respecting patient information which the consultant in question initially took. Sarayah's initial impressions were that a protection of one's information had to be requested as otherwise it was an expectation for her that this would be divulged as a matter of course. From Sarayah's perspective what she was observing from the consultant initially was not what she understood to be appropriate behaviour, thus causing her to question what the correct course of action would be.

Sarayah demonstrated that as she progressed through medical school, she learnt that she was able to discuss her cases within a professional context as part of her learning, but was also aware that it was required that patient's personal identifiable information was protected.

Sarayah - I've never seen a doctor say a patient's name in front of… even to discuss in front of other people who are unrelated, so they do adhere to.. They

do discuss in clinics in front of other patients but they don't say the name, so that patient will not know, unless it's a really unique case and suddenly they will know the person. But that's a unique case…

Sarayah demonstrated that she understood that it is not ideal to discuss patients in front of others, but she also observed that the use of patient identifiable data, such as names, was not used. This approach offered some protection and limited breach of confidentiality. Similar to her earlier observation of a patient case not being privately discussed (chapter 5 p. 120), Sarayah appreciated that confidentiality was respected. She was aware that information may be disclosed in circumstances that may warrant a case discussion to take place with the relevant personnel but, however, measures are taken to minimize the risk of patients being identified by those outside the medical team.

Consequences

The participants' experiences resulted in uncertainty about actions and appropriateness of decisions. This challenged the adequacy of their personal constructs in anticipating outcomes arising from specific situations, thus leading individuals to experience cognitive anxiety (Viney & Westbrook 1976). In having one's personal constructs challenged, the individual has to evaluate the utility of these constructs in working within a given situation. As a consequence of this, an individual will decide whether to abandon this as a redundant construct, change the construct/develop new ones or adapt how and when the construct is applicable (Kelly 1976). The participants demonstrated evidence of the latter. An example of this was the participants' approach to confidentiality. Pei-Jing for example (see p.175) was aware of the need for confidentiality and the measures she had observed that ensure that this was maintained. However, she noted that in Malaysia it was a cultural norm that all information is shared and discussed with the patients' relatives without gaining the patients' consent to do so. Thus, she stated "that is an unwritten rule in Malaysia that you can tell whoever." As a result, participants appreciated the need to adapt the delivery of care to meet the needs of the patients within a specific care environment and be culturally sensitive in their approach to ethical practice, and this forms the final part of the model of ethical sensitivity.

Recognising cultural differences in delivery of care

For the participants, the goals they felt they needed to achieve were that of beneficence (doing good) and non-maleficence (doing no harm). However, they perceived that although this was every clinician's overall aim, there were different ways of achieving it. Pei-Jing indicated that behaviours are culturally ingrained. She acknowledged that it is not simply doctors' approach that is reliant on this culture, but it is also the expectations of the patients that also influences practice.

> *Pei-Jing– it's because of the culture its different, and although we are here we can see that it makes sense yes keeping confidentiality that's not bad, that it makes sense, explaining and gaining consent is quite a good thing. It's just that in Malaysia, the patients don't have the same mindset as the patients here. The patients in Malaysia don't care as long as you tell them what to do*

Although Pei-Jing was speaking of the impact of the patient culture on the attitude towards protecting patient confidentiality, Eu-Meh shared an experience in which she observed the possible reality of invoking cultural change within the system. She observed

> *Eu-Meh - One doctor would shout at the patients and the other would talk very nicely and professionally to the patients. She didn't study here, but he did his MRCP here, and even though he has been in Malaysia for five years he has a lot of empathy for the patients. So, I think its human personality. I understand that some patients are…, some patients don't appreciate how much we try for them. As long as we see doctors applying what they've learnt, I think the main thing is, I think we should try our best, even though it's difficult. But this doctor showed me it can be done, and the patient was much happier, not like on the other ward round. This group of patients were so happy.*

Although Eu-Meh suggested that personality is influential in the doctor-patient interaction, her stance is captured by the phrase "we should at least try!" This indicated that she is aware of the limitations of making changes and, in reality, it may simply be just the care of "her" patients that she can influence. Lutfi stressed a

similar idea when he spoke of having to reach a senior level in order to be in a position to introduce cultural change to a health system.

> *Lutfi - When things have become so culturally integrated, it's a headache, because you have seen something else, and you think, why not, we have seen some good things that than be practiced at home. But again, it's not a one man show. Maybe I can practice that and have critics about this and that. And then the question is, am I strong enough to go through and get to specialist level where I've got the authority, and say "I am the authority now!" "I've got the power, I need you to do this, because this is how it should be done!"*

Lutfi acknowledged that the reality of changing practice is not easy. In the above comment, he also questioned his resilience within the system in order to able achieve these changes, when the reality was that he would be working against the nature of the existing culture. Ibrah spoke about respecting cultural differences and incorporating cultural norms within conventional medicine.

> *Ibrah - but in Malaysia we focus on alternative medicine as well. Because we have the Chinese there, and they have their own medicine and the Indians have their own traditional medicine and the same applies to Malays people. The younger generation are more likely to give options to patients in comparison to "old school" doctors*

Ibrah was describing his views about a cultural shift in younger generations of doctors that he perceived are more inclined to accept the patients' wishes to have traditional forms of medicine in keeping with their cultural norms and beliefs. In her interview, Ibrah had commented on how she had noticed this practice in the UK, where she observed doctors' acceptance of patients' use of alternative and complimentary medicines. Ibrah showed that she observed a partnership between doctors and their patients, allowing for a degree of autonomy and choice for patients.

These accounts demonstrate the participants' ability to adapt to the needs and context of the situations they encountered. The participants have very clear objectives on what they need to achieve for their patients in the form of beneficence and non-maleficence. The challenge for them is the ability to achieve this within the different clinical and cultural scenarios. The cognitive anxiety that they experienced

through challenges to their personal constructs supports their adaptability to these scenarios. The participants realised that, in some situations, their personal constructs needed to be abandoned and new ones developed, whilst in others they need to consider the circumstances in which these constructs would be applicable.

Summary

Being a student of a partner medical school programme is a unique feature of the study population. As an antecedent, being on a partner medical school programme adds to the originality of this study, but it also opens the model to populations that share similar aspects such as those studying/working in medicine (or other healthcare professions) within different countries.

As a consequence of completing their medical education through a partner medical school programme, the participants inevitably spoke of their experiences of clinical practice in the contexts of the UK and Malaysia. This provided a framework for them to discuss the impact of culture, religion and socioeconomic factors on the delivery of healthcare.

The cultural context of healthcare played an important role in the individuals' experiences. It was an aspect of care that required careful consideration of the application of the ethical dimensions of practice, appropriate behaviour and how to best meet the needs and expectations of the patients. This awareness of different approaches to care, the application of ethical principles and how the ethical dimensions of practice are responded to, gives rise to uncertainty with regards what is considered to be appropriate action and behaviour within a given situation. The following section will discuss and present the model of ethical sensitivity, with its corresponding elements.

A discussion of ethical sensitivity

Weaver (2007) states that although all authors agree that ethical sensitivity is vital to practice, enabling nurses and other professionals to respond morally to the needs of those receiving care, there has been no consensus on its definition, characteristics or the conditions needed for it to occur. In her paper, Weaver (2007) makes reference to medical practice in the same context as nursing, and talks about "the nursing and medical setting" or "medical and nursing knowledge" (Weaver 2007:144) Thus although Weaver predominantly addresses issues in nursing practice, in this paper and other works (Weaver et al. 2008), ethical sensitivity is extended to a "transprofessional" population to incorporate other disciplines within healthcare. Weaver (2007) focuses on the need for further research into ethical sensitivity, and within the literature on ethical sensitivity there is an existing gap in the knowledge of how this is developed in medical students, which is further discussed in chapter 7. Because of the variety of terms used to describe the concept of ethical sensitivity, a literature search on the terms "ethical sensitivity, ethical awareness, moral sensitivity, value sensitivity, medical education, medical students, doctors, physicians" in Pubmed, Cinahl, Psychinfo and Evidence Search was conducted and generated 18 hits. Of these 18 hits, 4 had already been identified in this thesis through the initial literature search and review on ethical sensitivity, with one of these based on the measurement of ethical sensitivity in medical students (Herbert et al. 1992). The focus of Herbert et al.'s (1992) study was to assess the efficacy of clinical vignettes in measuring ethical sensitivity in medical students. What is not researched in this study is how ethical sensitivity develops, nor were these students undertaking a partner medical school programme. Saying this, however, what Herbert et al. (1992) propose is that ethical sensitivity should be of interest to medical educators and state that their findings show that level of ethical sensitivity of medical students decreases with the length of time at medical school (p.145).

Ersoy and Goz (2001) focused on measuring the ethical sensitivity of nurses in Turkey through the use of scenario-based assessments. Their conclusion was that there is a call for more clinical ethics education for nurses to enable them to gain the skills for ethical decision-making, as experience facilitates the work of nurses when faced with ethical dilemmas (p.309). Further to this, Ersoy et al. (2003) studied the ethical sensitivity of physicians in Turkey using the same methods of case-based

scenarios as for their study on nurses for the assessment. This study concluded that physicians' levels of ethical sensitivity are variable and propose that there is a need for further training. Although both studies have focused on different sample populations, they do highlight a gap in the education of these professionals. A study by Kirilmaz et al. (2015) researched the ethical sensitivity of healthcare professionals and the factors that influence the level of ethical sensitivity. The factors they explored were marital status, sex, profession, age, clinical working and if ethics education had been received. They concluded that these variables affected professionals' sensitivity to some of the ethical dimensions of practice but not others, e.g. professionals who had children were found to be more sensitive to issues of autonomy compared to those who did not have children. What this study did conclude was that ethical sensitivity increased with an increase in years of experience, which differs to the conclusion reached by Herbert et al. (1992), with regards to the declining sensitivity of medical students with time.

In relation to this PhD study, the existing research demonstrates that experience is a key factor in the development of ethical sensitivity and thus experiential learning is an important feature in medical ethics education. Whilst Kirilmaz et al. (2015) included "ethics education" as a correlation to ethical sensitivity in their study, what they did not elaborate on was the type or level of ethics education and the type of programmes that these professionals had undertaken and, as such, there was no discussion of professionals having completed a partner medical school programme taking part in their study.

Yet, much of the literature e.g. Herbert et al. (1992) and Ersoy and Goz (2001) and Ersoy et al. (2003) addressed the measurement of ethical sensitivity and/or the evaluation of tools used to measure ethical sensitivity in various professions such as dentists, nurses and doctors. Although the literature on doctors did not state the level of professional development of the doctors, they were referred to as "physicians" and members of an Association of Physicians, indicating that these were not junior doctors. These authors did not address the issue of how ethical sensitivity in medical students is developed but focused on how ethical sensitivity can be assessed and

measured within that population. There are other authors such as Rest (1986) who have developed models on

Robichaux (2012) places great emphasis on ethical sensitivity stating that

> Ethical sensitivity is also the capacity to feel and be moved by others to identify their distress, to be aware of how one actions or inaction may affect them, and to assume a sense of responsibility and obligation. Before reasoning an action can occur, a nurse must recognise that an ethical situation exists (p212)

Robichaux (2012) further suggests that sensitivity is essential to the "development of ethically competent reasoning and nursing practice" (p212). Whilst Robichaux focuses on nursing it could be argued that other healthcare professionals, including medics, engage in ethical situations, recognize ethical issues in practice and make ethical decisions. The arguments that Robichaux develops could therefore be applied to the population of interest to this study. In addition, other authors such as Rest (1986) see ethical sensitivity as a key component in the development of ethical character.

According to Pettersen et al. (2018), ethical competence includes the ability to act upon ethical judgments. Thus, as per Rest's (1986) model, ethical sensitivity precedes ethical judgment, with ethical judgment leading to ethical competence. It demonstrates a strong association between ethical sensitivity and ethical competence, with ethical sensitivity being at the root of this developmental process. In addition, ethical judgment forms part of the decision-making process, with subsequent parts of Rest's (1986) model leading to implementation of these decisions. Robichaux (2012) supports the role of ethical sensitivity in the development of practitioners' ability to analyse a situation and identify alternative courses of action and the potential effects of these on patients and their families, as well as colleagues.

This is supported by Savulescu et al. (1999), who argue that patient care can be enhanced through the improvement of the ethical sensitivity and analytical skills of doctors. However, within the differences of the definitions of ethical sensitivity there are commonalities in what they perceive as being its defining features. Milliken (2018:278) identifies ethical sensitivity as

a foundational component of ethical action". Diminished or absent ethical sensitivity can result in ethical incongruent care, which is inconsistent with the professional obligations of nursing

From the various definitions, there appears to be some agreement on what is expected of a person with ethical sensitivity. These include a person's ability to assess/interpret a situation, identify the ethical issues and draw a conclusion as to the appropriate response to the situation, all whilst accounting for the needs of the patient receiving care.

A model of the factors that influence ethical sensitivity in students on a partner medical school programme

Further analysis and interpretation of the findings have been presented in this chapter using an evolutionary concept analysis model. The following section presents a diagrammatic representation of how Malaysian medical students on a partner medical school programme develop their understanding of the ethical dimensions of practice. The model illustrates the interaction between key elements and how these influence the students' sensitivity to ethical dimensions of practice. Acquisition of knowledge from their varied clinical placements that are completed in partner medical programmes enables students to develop understanding of ethical issues and ethical approaches to the delivery of healthcare. As they continuously develop their understanding, they have increasing resources to question and challenge what they observe. This can result in them experiencing cognitive anxiety. Cognitive anxiety does in itself propagate further challenging, questioning and reflecting on experiences, contributing to a cycle of deepening understanding of this aspect of professional practice.

A worked example from the findings that have previously been presented demonstrates the purpose of the model. It provides an illustration of the myriad experiences and influences faced by students on a partner medical programme, all of which influence the participants' understanding of the ethical dimensions of practice and potentially lead to cognitive anxiety. The development of ethical sensitivity arose as a result of the interaction between the elements that have been discussed throughout this chapter.

Lutfi's story as a worked example of the model of ethical sensitivity

Lutfi will be used as an exemplar case. His journey through the partner medical school programme highlighted how his biography and personal beliefs were challenged throughout his clinical experiences.

Amongst other issues Lutfi's discussions focused on issues of consent,confidentiality and privacy and dignity. He spoke of a situation whilst on placement in Malaysia in

which he had found himself needing to perform intimate examinations on patients in the presence of other patients (see p.141). At times, patients were of the opposite sex and there were no separate rooms, cubicles or curtains to prevent exposure of the patients to others. Lutfi had raised this as a concern to his supervisors, as he did not feel that this was appropriate. In addition, some of the patients did not speak Malay and were unable to consent appropriately. However, Lutfi explained that the examinations were required in order for the patients to receive care and therefore, overall, it was considered as the best course of action to continue with the provision of care in order to aid the patient's recovery, albeit in surroundings that did not support the confidentiality, privacy and dignity of the patient, as discussed in more detail in p.135-145 of the previous chapter.

A summary of Lutfi's biography

Lutfi was one of the participants that was of Malaysian origin and had been raised in Malaysia where his family still resided. Throughout the interview, Lutfi expressed his religious beliefs, stating he was Muslim, and showed his feelings about the importance of religious values in underpinning the doctors' working life to support them acting in a dutiful manner. Lutfi's references to duty-based ethics suggested that his ethical and moral development was based on deontology. Lutfi had completed years 1 and 2 of the medical degree in Malaysia and years 3,4 and 5 in the UK. He had expressed a wish to attend an overseas university to become acquainted with a different culture, and felt he had achieved this through the partner medical school programme. He also felt he had learnt a great deal from the programme about both medicine and the people of the UK. Lutfi showed that he was uncertain about transferring some of his learning to the clinical environment upon his return to Malaysia, although he felt he had acquired knowledge that would lead to improved practice. However, he expressed concerns about the possibility of changing practice in his new working environment in a culture that had long been established, especially as a junior doctor facing a hierarchical system.

Figure 3 (previously presented on p.156) is presented below to illustrate the original presentation of the model alongside a worked example of the model

(Figure 6). In Figure 6, Lutfi's experience is presented within the model to illustrate the relationship between the antecedents, attributes and consequences of the elements of the participants' understanding of the ethical dimensions of healthcare and of cognitive anxiety, and how these influence the students' sensitivity to ethical issues in practice.

Figure 3:
Diagrammatic model of the factors that influence ethical sensitivity to the ethical dimensions of healthcare for students on a partner medical school programme

Figure 6 An illustration of the model of ethical sensitivity and its application to the findings

Reviewing Outcomes
- Patient had the procedure and treatment planned
- Lutfi reflected on the situation and evaluated outcomes which added to his knowledge of the complex issues which arise in clinical practice

Ethical Issue in Practice
- Lutfi is requested to perform a rectal examination on a female
- Other male patients present in the same room
- No chaperone for the patient
- Patient did not speak Malay

Making an Ethical Decision
- Lutfi determined how the greatest good and the least harm could be achieved for this patient

Ethical Sensitivity of Students on a Partner Medical School Programme

Awareness and Identification of Ethical Issues
- Lutfi was aware that the patient did not understand procedure for examination but had observed a different approach in the UK where obtaining informed consent was obtained and measures taken to aid the patient's understanding
- Lutfi was aware that exposure of females in presence of males is culturally unacceptable and had experienced a different approach of this on his placements in the UK where male and females were not exposed in each other's presence
- Lutfi recognised that there was a lack of privacy for patient in this clinical area
- Lutfi recognised the need to make a decision as to whether to perform the procedure or not
- Lutfi aware that patient was an immigrant and may not have access to care

Uncertainty and Cognitive Anxiety
- Uncertain as to the most appropriate action
- Lutfi was anxious that the patient needed treatment yet the clinical situation would undermine her privacy and dignity

Understanding of Ethical Practice
- Patient's right to informed consent
- Patient's right to privacy
- Respecting the patient's beliefs and values
- Drawing on previous clinical experiences and different approaches taken by clinicians

A discussion of the model of ethical sensitivity

Evidence from the data illustrated that the participants' experiences in the clinical area greatly contributed to their understanding of the ethical dimensions of healthcare. The model accounts for the participants' personhood as precursors to how their understanding of ethical aspects of healthcare changes, in addition to cultural, religious and societal norms of patients and countries and how these shaped the participants' perceptions of the experiences they encounter throughout their medical education.

The participants observed the complex nature of working in the clinical area that drove doctors to adopt alternative approaches when interacting with their patients. These included time constraints, workload issues and facilities available, as well as cultural influences and values of both the patient and the physicians. Cultural issues

such as the role of the family, however, were a feature of clinical practice which offered the participants an alternative perspective in the delivery of holistic care, as they identified both a patient-centric and family-centred approach to holism. All these experiences enabled the participants to develop an understanding that allowed them to account for context when faced with challenging situations.

The participants drew comparisons between their practice in different settings and this led them to question and challenge the ethical practices they had observed. Moreover, the participants' ability to identify issues associated with ethical practices, demonstrated their sensitivity to these and other pertinent subthemes, such as language and communication, issues of inequality in the healthcare system and patient choice.

The role of cognitive anxiety in developing ethical sensitivity

The existing literature on cognitive anxiety addresses performance anxiety in academic or sports performance (Fazey & Hardy 1988; Woodman & Hardy 2003; Stenling 2015; Vitasari 2005) and not medicine and other healthcare professions. The definitions of cognitive anxiety relate to self-doubt and concerns about performance (Fazey & Hardy 1988), with Woodman & Hardy (2004) talking about cognitive anxiety being about a person's negative expectations, concerns about oneself and the potential consequences of the situation at hand. In addition, Stengling et al. (2014) attributed cognitive anxiety to being negatively influenced with a failure of achieving set goals. With regards to healthcare practitioners, Jameton (1984) and Sporrong et al. (2007) speak of moral distress and not cognitive anxiety. Cognitive anxiety and moral distress are distinct from each other. In 1984 Jameton, introduced the concept of moral distress as the experience of knowing the right thing to do while being in a situation in which it is nearly impossible to do it (Jameton 1984;2017). Jameton (1984) spoke of two catergories of moral distress

> initial and reactive moral distress. The former is due to organizational barriers and conflicts with another's values and is characterized by hopelessness, anger, and anxiety. The latter is due to leaving the former type of moral distress unresolved and is characterized by tolerance, compromise, silence, and getting used to the situations (page:2017).

Throughout discussion of the findings, it was evident that there were features within clinical practice of how the ethical dimensions of practice were engaged with, and at times these were a cause of internal conflict for the participants. The most prominent circumstances where anxiety occurred for these individuals were those pertaining to issues of beliefs and values, privacy and dignity, consent and confidentiality.

The participants demonstrated a degree of conflict between their own personal beliefs and values and the practices they observed in the clinical area, but in addition they spoke of how the patients' own beliefs and values also influenced practice. In other instances, such as their experiences of situations that involved consent and confidentiality, conflict existed between the theoretical knowledge they had acquired and the practices they had observed which led to cognitive anxiety. They therefore questioned the appropriateness of these behaviours and their effect on patient care, and considered these in relation to their future practice.

Cognitive anxiety therefore presented in a number of ways. As discussed earlier in this section, achieving set objectives has a positive impact on a person's anxiety. However, the challenge for these individuals is that the goals and objectives change. Thus, when working towards an objective based on specific values and knowledge, a challenge or conflict to these may change the objective and thus cause uncertainty on what needs to be achieved and how. This uncertainty results in these individuals questioning the suitability of their personal constructs to anticipate or predict the outcomes in specific situations, which in turn causes anxiety. For these participants, the aim is to be able to make ethical decisions within clinical practice, but due to the variation of practices they have encountered they have cognitive anxiety due to the fluid nature of this aim dependent on the clinical environment. However, an attempt to reduce anxiety by aiming to achieve a new objective, will result in the need to acquire knowledge and understanding, which in turn will further enable an understanding of the factors which influence the ethical dimensions of practice and, in line with the cyclical nature of the model (as seen in Figure 6), will lead to further questioning which may again return to cognitive anxiety.

The participants indicated that they were determined to practice in a particular way, which links with cognitive anxiety as they questioned whether this practice would be possible. They demonstrated a level of understanding in which they could incorporate various approaches and taper these to the needs of the situation. Confidentiality, privacy and dignity were aspects of care which they had all spoken about. They had all expressed a wish to maintain patient confidentiality and ensure that their patients were treated with dignity. However, they displayed an awareness of the factors that could act as barriers to them being able to exercise these fully, such as the cultural attitudes of health systems/practitioners as expressed by Lutfi and Eu-Meh, in which they considered the reality of the possibility of them making changes to clinical practice. This demonstrated a degree of insight into their own abilities and the real challenges that will face them based on their range of experiences and how they will negotiate solutions to the myriad dilemmas that could arise.

There are key features associated with ethical sensitivity which include the ability to: assess or interpret a situation; identify the ethical issues; and draw a conclusion as to the appropriate response to a situation whilst accounting for the needs of the patient receiving care. From the themes presented in chapter 5 findings it is evident that the participants' diverse experiences fueled their motivation to question, challenge and reflect on said experiences. This in turn enabled them to assess/interpret situations by considering what they had learnt through developing their understanding of the ethical dimensions of practice, as well as being able to identify the ethical issues and offer an appropriate response. However, what denoted a level of ethical sensitivity was their ability to identify and relate to the more subtle underpinnings of the ethical dimensions of practice, which they achieved through engaging in the cyclical process between the elements of understanding the ethical dimensions of healthcare and cognitive anxiety, as depicted in the model.

Chapter summary

This chapter has presented further analysis of the findings presented in Chapter 5. It has argued that the participants possess ethical sensitivity gained through their

experiences and complex relationships between their expectations and the reality of clinical practice. Through this, however, the students demonstrated an ability to consider additional aspects such as the context of a given situation with regards to ethical reasoning.

Presentation of the model of ethical sensitivity using an evolutionary model for concept analysis has enabled detailed discussion of the influences and challenges faced by the participants that impact their development of ethical sensitivity. The model has provided a diagrammatic presentation of the findings of this study. The component parts of the model account for a myriad of factors which lead to the development of ethical sensitivity and include cognition, action and behaviour, all of which are contributory factors in how ethical sensitivity is developed by students on a partner medical school programme.

The following chapter will present a detailed discussion on the findings on ethical sensitivity and the model. It will explore the literature and existing research on this topic and relate this to the findings from this study and highlighting the contribution that this study has made to this field. Through this discussion, the position of this study within the wider research on medical ethics and its implications on future practice will also be explored.

Chapter 7

Introduction

This PhD study has explored partner medical school students' experiences of a variety of clinical placements and their resulting exposure to ethical issues that exist in healthcare practice. The study has identified the significance of the interrelationship between the students' exposure to ethical issues in practice and the role of cognitive anxiety in developing ethical sensitivity. Through further analysis of the findings, Chapter 6 illustrates how the participants experienced cognitive anxiety through their exposure to various and conflicting clinical practices, as well as challenges to their own personal beliefs and values. The participants developed an appreciation of the complexities involved in patient care and how factors such as beliefs, values and culture influenced the approach towards the ethical dimensions of practice. The findings highlight that it was not solely the exposure to a range of experiences in different healthcare setting that promoted the participants' understanding of the factors influencing the ethical dimensions of healthcare, but also the continuous challenge to their existing knowledge. This included challenges to their own beliefs and values, whilst they, in turn, challenged the practices they observed and the decisions that they were required to make.

Whilst previous studies have explored approaches to medical ethics education and cultural issues, this study has provided a fresh perspective about the student experience and consequences of the role of the partner medical school programme in medical education. The participants were a unique population who completed a partner medical school programme between Malaysia and the UK. This medical programme provided the opportunity of completing clinical placements in very diverse healthcare settings. These experiences influenced the participants' understanding of ethics by exposing them to alternative approaches in response to the ethical issues that were inherent in practice.

Overview of key findings

The key findings of this study show that partner medical school students can identify ethical issues in healthcare situations and that they demonstrate ethical sensitivity in their practice. These students also experience conflict, uncertainty and cognitive anxiety when they make decisions about the appropriateness of actions and approaches to the delivery of healthcare. Their uncertainty of the rightness of actions and the application of different practice approaches in different situations prompted them to engage with their existing knowledge, thereby reflecting in practice and contributing to the continuous development of their sensitivity to ethical issues within healthcare. Further analysis and interpretation of the findings were presented in the previous chapter and culminated in the development of a model of ethical sensitivity.

Adopting an interpretive methodology to the study and using semi structured interviews allowed for the collection of rich data. The interviews generated depth of discussion and the use of an interview guide allowed for digression but within context of the aims and objectives of the study. Thematic analysis allowed for an immersion of the researcher within the data, creating a depth of the knowledge of the participants and their experiences, as well as extending through to the data interpretation and analysis process.

Acquiring ethical sensitivity through a partner medical school programme

Ethical sensitivity is a concept that is increasingly being debated by healthcare professionals, particularly in nursing and, to a limited extent, in medicine. To place the findings of this study in the context of the wider body of research a literature review on ethical sensitivity using "ethical sensitivity in medical education" as the search question was conducted.

This thesis contributes a new and original perspective on how ethical sensitivity is developed in a population that has not been previously studied. Moreover, this thesis did not focus on the measurement of the level of ethical sensitivity nor did it set out to evaluate the accuracy of a tool for the measurement of ethical sensitivity. This

study concluded that ethical sensitivity developed in this population due to a complex relationship between a number of contributory factors attributed to being on a partner medical school programme.

The significance of developing ethical sensitivity

Within the wider literature discussions exist to support that having ethical sensitivity is a pre-cursor to achieving ethical competence (Lechasseur 2016; Robichaux 2015). These authors do not offer a definition of ethical competence but instead propose a set of terms that describe ethical competence as "the ability to recognise ethical problems," "the ability to deal with uncertainty," "the identification of an ethical issue and considering the viable options." In addition to Savulescu et al. (1999), Lechasseur (2010) also presents ethical sensitivity as a descriptor of ethical competence, and Mitchell et al. (1993) claim that ethical competence involves the conceptual moral reasoning and interactional abilities to deal with most ethical issues raised by patient care in daily practice and ways in which to improve said care. Although Mitchell et al. (1993) speak of ethical sensitivity, their research focused on measuring the effect of teaching medical ethics on students' behaviour in the clinical area and did not explore how students develop ethical sensitivity. However, Petterssen et al. (2018) state that ethical competence can be defined as the capacity to handle tasks that involve ethical dilemmas adequately and in an ethically responsible manner. Ethical competence was not assessed within this PhD study, but the literature shows a strong link between ethical sensitivity and ethical competence, hence the relevance to clinical practice. Therefore, the relationship between ethical sensitivity and ethical competence should be a topic of future research.

Partner medical school programmes offer students an alternative approach to learning medicine, with students experiencing practices in two distinct national contexts. Within healthcare settings, the students observe how the ethical dimensions of practice are recognised in clinical practice. The findings show that this type of programme gives students insight into a range of aspects across a spectrum of healthcare systems and is supported by the existing research on ethical sensitivity.

Borhani et al.'s study (2013) aimed to explore how nursing students understood the factors that influenced ethical sensitivity. Their findings indicated that an individual's level of ethical sensitivity was influenced by their spirituality, education, mutual understanding and experience of immoral acts. Ertug et al. (2014) also commented that the degree of ethical sensitivity that an individual possesses is influenced by their ethics education, age and educational background. Both studies explored these issues and the influence on development of ethical sensitivity. What these authors highlight is the importance of ethics education and educational background as a factor influencing the level of ethical sensitivity possessed by an individual. This PhD study has demonstrated similar findings to these studies. It could be suggested that there may be consistent factors that impact on the development of ethical sensitivity amongst a variety of professional groups.

The relationship of ethical competence to this study

Ethical competence was discussed in the literature review chapter, showing discussions on how ethical competence is best assessed i.e. via group discussions, portfolios or OSCEs (Mitchell et al 1993; Savulescu et al 1999; Boon & Turner 2004). The General Medical Council state the importance of ethical competence in medical practice. This study has shown that students on partner medical school programmes demonstrate ethical sensitivity.

It is interesting that one feature that triggered interest in this topic was how students on partner medical school programmes asked how they could pass an "Ethics Station" in an OSCE as discussed in Chapter 1, p. 3. This shows their knowledge that their ethical competence is assessed in this situation. Their question highlights their uncertainty about how to demonstrate their ethical competence and present a right answer. Ethical competence is a dominant feature throughout the literature on medical ethics teaching. It is therefore prudent to discuss it here as it is also an important feature of the medical ethical guidance from the GMC, as well as establishing a connection between my study and the wider research on medical ethics.

In this study the participants were able to identify a range of key ethical issues, dimensions and principles from the variety of clinical experiences they encountered. They demonstrated an appreciation of the complex factors that could impact the delivery of care, different decision-making process and ethical sensitivity. In the context of personal and professional accountability, clinicians must have well-considered, justifiable and defensible reasons for decisions made in clinical practice (American Medical Association 2009; General Medical Council 2009). In recognition of this, many medical undergraduate programmes include opportunities for students to develop skills that enable them to analyse and resolve ethical dilemmas as an essential professional skill and a goal of medical ethics education (Manson, 2012, p.258). The partner medical school programme provides students with the opportunity to encounter a variety of experiences within clinical practice and observe the complexities of ethical decision-making in the clinical settings across distinct settings. Thus, in light of the references above by the GMC, AMA and Manson (2012), the findings of this study suggest that the partner medical school programme creates opportunities which enable the students to develop the analytical and problem-solving skills required for ethical decision-making.

In chapter 2, the benefits of experiential learning, with particular relevance to medical ethics, was presented. In addition, authors such as Elit et al. (2011) and Tubman et al. (2017) discuss the benefits of global/international health electives for medical students. The partner medical school programme offers a unique experience to medical students as it exposes them to diverse clinical placements in different healthcare systems, cultures and working environments. Unlike other global health electives which are usually of short duration of 6-8 weeks, the students on the partner programme, are exposed to an international placement for 3 years during which they are offered individual reflective support by an academic advisor in the development of a professional portfolio. Thus, this aids the ongoing development of their ethical understanding. In addition, both Elit et al. (2011) and Tubman et al. (2017) focus on health electives involving sample populations from Canada. Tubman et al. (2017) describe their sample as "medical trainees", but do not offer clarification if this term refers to medical students or junior doctors. Elit et al. (2011) however, based their study on medical students at a Canadian university. This is significant as

Malaysian medical students are an under-reported population, whereas there is existing research involving Canadian medical students including Mitchell et al. (1993) and Herbert et al. (1992).

There are no evaluations of the partner programme, but the findings of this study show that the students on the programme have experiences with which they create strong connections and challenge their pre-conceptions, beliefs and values. As presented in chapter 6, it is through this questioning and reflection that the understanding of the ethical dimensions of practice occurs. As presented in chapter 6 it is through the dynamic interrelationship between this questioning and reflection, and the resulting cognitive anxiety that can arise, that the development of ethical sensitivity emerges.

A key component of experiential learning as proposed by Kolb (1986) is reflection. From the presentation of Lutfi's case as a working example of the model, it can be seen how reflection forms part of the process that leads to the development of the students' ethical sensitivity.

The model of ethical sensitivity in relation to existing models

Within the healthcare ethics literature there are models which incorporate ethical sensitivity. The model of ethical sensitivity developed through this study is not a tool to be used in the deliberation of ethical dilemmas nor for measuring the level of ethical sensitivity, unlike models such as Rest & Narvaez's (1994) four component model which has been used (e.g. Huang et al. 2017) as a tool in the identification and measurement of ethical sensitivity in health professionals. Within Rest and Narvaez's (1994) model ethical sensitivity is the first component, suggesting that ethical sensitivity is key factor in moral behaviour.

The participants in this PhD study developed their ethical sensitivity through the development of knowledge, understanding and reflections on their observations and experiences. However, applications of being, doing and knowing are used by authors such as Nobel & McIlveen (2012), who apply this to constructing professional identity and development of self-consciousness for the purposes of reflexivity.

The model of ethical sensitivity presented in this thesis provides an explanatory framework for how the students on a partner medical school programme develop ethical sensitivity. It demonstrates the link between the factors that influence students' understanding of the ethical dimensions of healthcare and the presence of cognitive anxiety, whilst also illustrating how these two components interact to influence the further development of ethical sensitivity in students completing partner medical school programmes. It allows for further insight and understanding of the challenges, such as experiencing conflicting practices between clinical placement areas, faced by these students with respect to how they develop their ethical sensitivity.

Cognitive anxiety

The participants spoke of how they encountered situations which conflicted with their own beliefs, values and expectations. However, they also demonstrated a level of confusion and uncertainty as to what they can predict to expect in a given situation or their future practice. One study by Parnabas et al. (2015) looked at the relationship between cognitive anxiety and performance in sport. The study concluded that an increase in cognitive anxiety results in a reduction in performance. However, they also concluded that more elite athletes demonstrated lower levels of cognitive anxiety. That is to say, elite athletes have a greater experience in a range of encounters and in coping with challenges that may arise. Therefore, outside of the context of sports, individuals who become more experienced at facing challenging situations are less likely to demonstrate cognitive anxiety.

The development of cognitive anxiety

The participants' view of their experiences was influenced by their personal biographies, beliefs, values and being taught on a partner medical school programme which led to the creation of personal constructs. According to Kelly (1955) personal constructs are responsible for how individuals view the world and what they expect from particular experiences. Personal construct theory is a

phenomenological approach as it aims to study how people view the world (Gross 2001). Personal constructs are fluid, as they can change depending on whether the construct is reinforced through recurring experiences or is altered if not. Individuals create a hypothesis (or construct) about an event and if the actions they anticipated occur, this hypothesis is reinforced and retained for future use. In contrast, if this hypothesis is incorrect, an individual will decide on the context of when the hypothesis is to be applied, if the construct is to be altered or whether or not to ultimately abandon this construct. The findings suggest that participants had created constructs about their expectations on ethical practices, such as consent and confidentiality see p.109-115 and p.131-137.

 A key to creating constructs is recurrence. The participants observed recurrence of conflicting practices within the various clinical environments (UK, Malaysia, private and public setting). Practices in the maintenance of confidentiality were a recurring theme within all clinical area. The participants observed how confidentiality was strictly respected by some consultants e.g. Sarayah p.134, but also observed the compromising of patient information when patient care was discussed in an open ward area (see p.121). In addition, Sarayah also expressed her own expectations of having her information divulged when attending the doctor's surgery in Malaysia, despite having an understanding of maintaining confidentiality (p.198). Sarayah's testimony illustrated the differences between approaches to confidentiality within the clinical environment, including her own expectations of care as a patient. These individuals have to make decisions about when and how to apply their constructs in relation to the clinical and cultural context. Cognitive anxiety therein occurs as the participants attempt to predict the course of action to take and anticipate the outcome when their objectives are unclear. Sarayah (see p.133) presented how she was uncertain about how to address the issue of patient confidentiality. Being informed by the consultant that she could not discuss anything seen in his clinic, gave rise to a level of anxiety for Sarayah as she did not know what could or could not be discussed, even for the purposes of her learning, and would not make comments about her experiences from her clinical placements. However, this anxiety led her to question the appropriateness of this strict approach and, in her interview, it was evident how this initial struggle to understand the concept of confidentiality led to questioning this approach, developing her knowledge and understanding of

confidentiality (see p. 133). Other participants demonstrated that they struggled with the uncertainties that their experiences in the clinical area led to and that it was not simply a case of assessing the different approaches. Nadia described her experiences pertaining to obtaining patient consent. She was aware of some of the accepted practices that existed in which consent for interacting with a patient was not sought by medical students, and she expressed her disapproval by stating that she did not engage in interactions with patients as she could not consent them. This suggests that Nadia had strong views on obtaining informed consent from her patients. This was further highlighted on p. 168, where Nadia's statement illustrated that she struggled with the practice she observed as she states that she observed doctors not consenting patients properly for surgery when "the patient could well die on the [operating] table." She concluded her statement by saying that the risks "need to be discussed with the patient." Nadia demonstrated that she has a degree of anxiety about these practices as she clearly stated what she believes is the correct approach. Her statement did not allude to her considering this as an alternative approach to consent, and she demonstrated that she feels this is not appropriate or acceptable practice. Thus her cognitive anxiety stemmed from the conflict that arose between her experiences and what she believed to be best practice. In both examples, the personal constructs of the individuals were being challenged, leading to cognitive anxiety.

Uncertainty and cognitive anxiety

Uncertainty is a concept which is written about in various disciplines in healthcare, including medicine (Wellbery 2010). Although in medicine assurances about diagnosis, prognosis and treatments are desirable, there is a need to recognize that there are medical practitioners who embrace uncertainty in medicine (Wellbery 2010). According to Simpkin & Schwartzstein (2016), physicians are aware when uncertainty exists but "the culture of medicine evinces a deep-rooted unwillingness to acknowledge and embrace it." Tannert et al. (2007) claim that there exist two types of uncertainty. First is an uncertainty of "rule-guided decisions" in situations where the guidance available does not offer appropriate information to support an individual in making a decision within a given situation. The second type of uncertainty stems

from having to make a decision based on one's own morality, which is therefore reliant on their intuition as opposed to knowledge. The uncertainty therefore lies on whether an individual's moral values are applicable and suitable to the situation at hand. According to Scutti (2016) uncertainty can cause stress for physicians when making decisions in clinical practice. However, Scutti (2016) stated that study participants whose stress levels were high in uncertain conditions proved themselves best at predicting outcomes of a situation.

With regards to the notion of the need to embrace uncertainty, in his interview Alwi (chapter 5 p. 147) stated that he struggled with how to break bad news to patients because his own personal preferences of being directly informed contradicted other approaches he had been exposed to, promoting a gradual approach to delivering sensitive information to patients. Alwi therefore considered it confusing, as he was uncertain on how to best perform this task. Other participants shared similar experiences. Eu-Meh and Naseem had commented on how they found it difficult to communicate with patients in Malaysia, as they had learnt medicine in English. They spoke of having to ask patients to wait whilst they asked how to explain specific conditions to their patients. Although this issue pertains to a language barrier, it made the participants demonstrate their uncertainty to their patients. This is uncommon in the doctor-patient relationship in Malaysia as doctors adhere to a paternalistic approach to care in which they perceive patients as being on a lower hierarchical level to themselves (Claramita et al 2011).

The participants in this PhD study spoke of circumstances in which the ethical dimensions of practice were not upheld and questioned decisions of others taken under those conditions, giving rise to uncertainty and concern as to what the most appropriate action should be. The participants were able to reflect on the experiences they had encountered and on different perspectives within the situations they observed. They reflected on why the doctors they had observed had acted in the manner they did and demonstrated an understanding as to why the decisions to act in this manner had taken place. They indicated that they understood these situations even when they disagreed with the actions they observed. They spoke of the contrasting experiences they observed in practice and drew on these, expressing confusion and a level of uncertainty about what the appropriate course of action

should be, but also uncertainty about their future actions as qualified doctors when the clinical environment posed challenges to their practice, as presented by Eu-Meh (see p.194).

It was evident that the participants were confused and uncertain about the variations that they observed in healthcare practice. Sarayah expressed that, from a personal perspective, she would not expect the details of her consultation to remain confidential. However, this expectation was challenged by a consultant who stated that confidentiality was absolute (chapter 5 p. 133), thus changing her existing construct. However, Sarayah demonstrated that these goals relating to confidentiality changed throughout her journey at medical school. From expecting absolute confidentiality, she found that patient information could be shared with others for the purposes of learning, without divulging identifiable information, but other experiences showed her times when patient information was discussed in a more public setting, risking it being overheard by those not directly associated with a patient's care. From a goal-setting perspective, cognitive anxiety can result as the goals change and create a sense of being unable achieve them due to uncertainty of what needs to be achieved.

Ethical background and the development of gognitive anxiety

In Chapter 2, Literature Review, a brief overview of the main philosophies which guide medical ethics was presented. The development of principalism (the 4 principles approach) by Beauchamp and Childress (1974) was a guide to the provision of ethically-sound care and has dominated the teaching of medical (and healthcare) ethics (Gillon 1994; NHS Scotland 2012). Within the background literature it was found that controversy exists in teaching principalism to students in countries in which other ethical philosophies are dominant. One example of this is China, where patient autonomy is not at the forefront of care and, thus, Yali (1997) argued that this is not relevant in the Chinese context.

The participants' previous ethical knowledge in this study was not predominantly based on principalism. With Islam being the main religion in Malaysia, this means that its core principles underpin state policies (including healthcare) and values. Lutfi

identified duty as a predominant feature of the healthcare and medical values as a Muslim, illustrating that deontology (duty-based ethics) is the philosophical stance that Malaysian medical ethics has its foundations in. For the participants, there was a transition from living and learning in an environment supported by a deontological stance to one which focuses on supporting autonomy of the person as a key feature of medical practice. The conflict here lay on the notion that their objectives had shifted from initially working towards an end goal of a duty-based perspective to that of a principalist approach in which the autonomous patient is at the centre of care. This change results in a level of cognitive anxiety within the participants from the perspective of (1) changing the end goal and (2) creating a change or challenge to existing ethical values. However, this is not to say that practices in the UK do not address duty ethics, as within codes of ethics the duties of doctors are clearly defined. Yet, in the UK dilemmas can arise between principles with regards to which should be prioritised. In such circumstances, there may be consideration for the greater duty.

Western hegemony, cognitive anxiety and ethical sensitivity

In Chapter 1 and 2, the issue of Western hegemony was discussed with regards to how Western ethics has infiltrated Eastern countries and the related medical ethics curricula. Yali (1997) and Qui (2004) argue that it is inappropriate to teach principalism within these countries, as what they described as "Western ethics" is based on autonomy and patient centredness, and Eastern philosophies are not predominantly based on these same beliefs. However, the findings of this study are suggestive that principlism was not the key ethical framework experienced by the participants on their placements in Malaysia. Thus, although one participant made reference to being taught the 4 principles, it was not recalled by the others.

Yet, in Chapter 1, there was discussion regarding Western medical practices being introduced into Malaysia during colonial times and overpowering traditional methods of medicine. One participant made reference to the need for traditional methods to be respected as there are some patients who would want to apply these within their care. Yet, from the participants' testimonies, there was nothing to suggest that they had experienced an imposition of Western medical practices or ethical principles within their home country that deemed itself superior to the existing practices. The

participants spoke of medical practices that mirrored those they experienced in the UK, such the use of X-rays and MRI scans, which depicted that there had been similar technological advances across both countries. However, this was not a factor which they described as being a result of Western hegemony, nor was the hegemony of Western ethics identified in the findings.

However, cognitive anxiety arose when students felt that they were in agreement with the Western ethics approach but did not observe it or were able to put it into practice in the Malaysian settings, as it did not align with culture and expectations of the clinicians or the patient population. There exists criticism for the teaching of the 4 principles in Asian countries, as discussed by Leavitt (1998) and Qui (2004) (see p.24) who speak of the imposition of Western ethics onto countries whose ethics are based not based on the same philosophical teachings. Leavitt (1998) was critical of Yali (1997), who taught the 4 principles to medical students in Beijing, suggesting that it was inappropriate. However, despite these criticisms of the use of the 4 principles in non-Western countries, the findings of this PhD study do not suggest that this was viewed as a controversial issue for the participants, but instead it was found that that the conflict arises in their agreement with these practices. Thus, it is worth considering if the 4 principles approach has practical universal applications and shared commonalities with other philosophical approaches, as opposed to it being a conflicting approach.

The literature reviewed in Chapter 2 by authors such Fuscaldo et al. (2010) and Aresculeratne (2006) demonstrate that there is a need for cultural sensitivity and the development of a cross-cultural understanding (Grol-Prokopczyck 2013) in medical education. What the findings of this thesis have shown is that the students on a partner medical school programme have experienced cognitive anxiety as a consequence of reflecting on the differing cultural practices they encountered. However, cognitive anxiety due to these varying practices, together with their development of an understanding of the ethical dimensions of practice, has led to the development of ethical sensitivity in these students. Therefore, it could be argued that working across cultures is beneficial in the ethical development of medical

students and a positive aspect of the partner medical school programme and cross-cultural collaborations in ethical development. Although there are a number of authors, such as Iserson et al. (2012) and Aresculteratne (2006), who call for a culturally sensitive approach, they do not establish a link between working cross-culturally and the benefits in the development of ethical understanding in students or professionals. Although there is literature to support international health electives, these authors mostly address the challenges faced by students and how these can be minimized, e.g. Elit et al. (2011) and Dell et al. (2014). However there is little to suggest the positive elements of these international placements in the development of ethical sensitivity in medical students.

Limitations to the study

The findings of the study are subject to some limitations. Acknowledging these aligns with the need for honesty and transparency as stated in the methods chapter.

Challenges of the sample

IMU offers students partnerships with various medical schools across the United Kingdom, the USA, Australia and Canada. However, this research focused only on student participants from one medical school in the UK working in partnership with IMU, Malaysia. Therefore, the sample population in this study is not fully representative of the full population of students within the partner medical school programmes. Despite this, however, the use of a small sample of participants allowed for in-depth semi-structured interviews, thus facilitating an in-depth exploration of issues and the development of rich data. This study focused on the experiences of one student population, which within our current global educational climate is of great importance. As stated in Chapter 1 (see pages 6-7), educational institutions need to be well prepared to meet the personal and education needs of overseas/international students (Andrade 2006; Teichler 1999). Therefore, exploring the experiences of this one student population aids in supporting them in their

experiences in the educational and clinical setting, as well as integrating with the home students.

In addition, the sample population in this study provided insight into how students develop their understanding between the Malaysian and UK settings. This however, limited the range of experiences captured. The partner medical school programme within Malaysia includes links with Australia, the USA and Canada as well as the UK. Thus, to explore the experiences of the students on a partner medical school programme within these countries would offer an opportunity to collect comparable data to that of this PhD study. It would allow for the exploration of how students on this programme develop their understanding of the ethical dimensions of practice from a wider global perspective by exploring the possible ethical challenges faced from having placements within these medical systems. This greater exploration would allow for an evaluation of the influence that the partner medical school programme has on the development of ethical sensitivity of students on the programme, as currently there is a lack of evidence to suggest that this programme has been subject to evaluation.

Challenges of the study design

This study was based within a single site and therefore this limited the number of participants and the experiences explored. Within the UK there are other universities that are part of the partner medical school programme, in addition to those within other countries. Therefore, to explore the research question further in the future a recommendation is to conduct similar studies across a number of sites in the countries included in this partnership with IMU.

A further challenge of the research design was that the data collected, and findings, were based on the participants' recollection of the events they spoke about. This has implications for the methods used as the study was reliant on the ability of the participants to recall events that had occurred over the 5-year period whilst at medical school. Alternative approaches to aid participant recollection of events could have involved a staged approach to interviewing. Options that could have been

considered would have been the interviewing of students at the point of entry to the UK to discuss their experiences in Malaysia, followed by a 2nd interview in year 5 or, alternatively, interviews at the end of years 3, 4,and 5, to capture their experiences within the UK. To further assist in collecting data from the participants closer to the time of the experience a longitudinal study could have been undertaken whereby the participants were followed from years 1 and 2 in Malaysia to years 3-5 in the UK, and interviewed at the end of each academic year.

Autobiographical reflection

Undertaking this research study has been a challenging yet invaluable experience. I have gained insight and understanding of the qualitative research process which has enabled me to learn the complex and often challenging nature of this type of inquiry. However, this research methodology has taught me the possibilities of its application as a data collection tool and the richness and detail that can be found within the data. It has also offered great insight into the reality of the lived experiences not only of a group of people who have not previously been the focus of research, but also about a group of people whom I had taught for a number of years but knew little about. It has developed a greater sense of inquiry, but having the knowledge from the participants is now a pre-cursor to asking questions of the overseas students without feeling apprehensive due to my lack of knowledge. It has been a realisation that students are keen to share their experiences and knowledge if I show an interest.

Therefore, conducting this study has allowed me to develop reflexive and analytical skills and, thus, has facilitated examining my own practices, especially in the light of previous assumptions about the sample population. Thus, an appreciation for the complexities that these students face in developing their understanding of ethics has been generated.

Contribution to knowledge

This study has illustrated the value of the partner medical school programme in the development of ethical sensitivity. Partner medical school programmes, as presented

in Chapter 1, offer a variety of benefits, however there are no existing evaluations of such programmes in relation to medical ethics. The structure of this programme, as discussed in Chapter 1, provided a varied and contrasting experience to the students who complete it, and this feature is a key contributor to their development of ethical sensitivity. There is currently no research on partner medical school programmes and this PhD study has provided new insight into the programme and its impact into the students' ethical development.

Future recommendations

This thesis has raised a number of questions that open the possibility for further research. An avenue for further research would be that of conducting a comparative study between home students and students on a partner medical school programme, investigating how both groups develop their understanding of the ethical dimensions of practice. Whilst this study has focused on a sample population from one partner medical school, future studies could explore if the phenomenon of developing ethical sensitivity is a common outcome for students on other partner medical school programmes. Further research into the way that medical students on partner programmes cope with uncertainty and cognitive anxiety would highlight the extent to which the findings of Parnabas et al. (2015) transfer across to medical education.

The existing body of knowledge, such as Savulescu et al. (1999) and Lechasseur (2010), describes a relationship between ethical sensitivity and achieving ethical competence. The findings of this study show that the participants do have ethical sensitivity but does not address the factor of the development of ethical competence within this population. However, this would be worthy of further investigation, with a view to ascertaining if these students are ethically competent and, if so, how comparable their level of competency is to those of home students that do not complete clinical placements in other countries. With reference to the literature on moral distress and its links to ethical sensitivity, it may be of purpose to further evaluate if students on a partner medical school programme exhibit signs of moral distress, explore levels of moral distress across both students on this programme and home students, and how these individuals cope with this level of distress.

Implications for medical education practice

The model of factors influencing the ethical sensitivity to the ethical dimensions of practice for students on a partner medical school rogramme shows the relationship between the numerous factors that lead to the development of ethical sensitivity. It will enable students and educators to understand the process through which ethical sensitivity is developed. The model is not in itself a reflective tool, but a model that can be used to aid the reflective process. It would allow students and their supervisors to consider all the factors highlighted within the model when de-briefing or reflecting on their own practice in relation to coping with ethical dilemmas. It aids students and educators in the understanding of the multifaceted experience which leads to the development of ethical sensitivity and making sense of the process. Although the model is based on findings from a study on medical students, it has practical applications for use with students or practitioners who have practice experience across various cultural settings.

Conclusion

This thesis provides a unique insight into the lived experiences of students on a partner medical school programme and how they develop their understanding of the ethical dimensions of practice. The overall aim of this study was to explore how Malaysian medical students on a partner medical school programme develop their understanding of the ethical dimensions of practice.

The use of semi-structured interviews as a method of data collection enables the participants to tell of their lived reality during the five-year medical programme and allowed me, as the researcher, to explore these experiences in detail. In addition, much has also been learnt about the students' pre-clinical years and the experience and knowledge that they bring with them upon starting their journey at the UK university. The study has revealed that the development of understanding of ethical issues is a complex and multi-factorial process. It can be concluded from the findings

that the students demonstrate sensitivity to ethical issues that arise in healthcare, together with an appreciation for alternative approaches to healthcare.

The model of ethical sensitivity that has been developed in this thesis offers a visual representation of the complex factors and challenges faced, which influence how these individuals develop ethical sensitivity. The model has applications for education, allowing educators of international medical students to understand the complex nature of how these individuals develop their understanding of the ethical dimensions of practice, leading on to the development of ethical sensitivity.

I commenced this journey with some understanding of the challenge that these students encountered when developing ethical skills. Exploration of their lived realities has allowed me to develop my own understanding of the influential factors in their development, which in the past I had been unaware of. This new understanding and knowledge will enable me to support students more optimally throughout the course. In addition, these individuals' understanding and sensitivity is a strength which they bring to the workforce. Thus, an appreciation of this could aid educators in educating a global workforce by ensuring that international students are offered support in their reflexivity and the cognitive anxiety they experience.

As medicine continues to extend as a global profession, so will the need to understand complex issues and challenges faced by our overseas students, and members of the workforce alike. Furthermore, as medical technologies continue to advance and be shared across the global medical community, new ethical challenges will arise. This will necessitate medical ethics and its education to evolve with a view to supporting our international students in understanding the ethical dimensions of practice in the future.

APPENDICES: A-F

Appendix A – Ethics Approval

IRAS Form

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Malaysian medical students and Western medical ethics

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial or clinical investigation

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

◉ Study involving qualitative methods only

○ Study limited to working with human tissue samples, other human biological samples and/or data *(specific project only)*

○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?   ○ Yes   ◉ No

b) Will you be taking new human tissue samples (or other human biological samples)?   ○ Yes   ◉ No

c) Will you be using existing human tissue samples (or other human biological samples)? ○ Yes   ◉ No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England

○ Scotland

○ Wales

○

○ This study does not involve the NHS

---

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ Ministry of Justice (MoJ)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

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5. Will any research sites in this study be NHS organisations?

◉ Yes   ○ No

5a. Do you want your NHS R&D application(s) to be processed through the NIHR Coordinated System for gaining NHS Permission?

○ Yes   ○ No

If yes, you must complete and submit the NIHR CSP Application Form immediately after completing this project filter, before proceeding with completing and submitting other applications.

---

6. Do you plan to include any participants who are children?

○ Yes   ◉ No

---

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes   ◉ No

Answer Yes if you plan to recruit participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

---

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes   ◉ No

---

9. Is the study, or any part of the study, being undertaken as an educational project?

◉ Yes   ○ No

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes   ○ No

---

10. Will this research be financially supported by the United States Department of Health and Human Services or any of

its divisions, agencies or programs?

○ Yes   ⦿ No

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11. Will identifiable patient data be accessed outside the clinical care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes   ⦿ No

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

◉ NHS site
◯ Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
AN EXPLORATION OF HOW MALAYSIAN MEDICAL STUDENTS ENGAGE WITH WESTERN MEDICAL ETHICS, WITH AN EMPHASIS ON THE ETHICAL PRINCIPLE OF AUTONOMY

Short title: Malaysian medical students and Western medical ethics

Chief Investigator:

	Title	Forename/Initials	Surname
	Miss	Claire M	Vassallo

Name of NHS Research Ethics Committee to which application for ethical review is being made:
NRES Committee North West

Project reference number from above REC:

1-1. Give the name of the NHS organisation responsible for this research site

Lancashire Teaching Hospitals

1-2. In which country is the research site located?

◉ England
◯ Wales
◯ Scotland
◯ Northern Ireland

1-3. Is the research site a GP practice or other Primary Care Organisation?

◯ Yes   ◉ No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

Select the appropriate title: ◉ Principal Investigator
                                 ○ Local Collaborator

	Title Forename/Initials Surname Miss Claire M Vassallo
Post	Clinical Skills Facilitator
Qualifications	BA(Hons)Midwifery MA Healthcare Ethics PG Dip in Midwifery and Higher Education Registered Midwife (RM)

, NHS Foundation Trust

tment

e Green Lane

Fax

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation?   ◉ Yes   ○ No

A copy of a <u>current CV</u> for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

Location	Activity/facilities

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes   ◉ No

7. What is the proposed local start and end date for the research at this site?

Start date: 05/09/2011

End date: 31/08/2015
Duration (Months):   48

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

    1. Total number of interventions/procedures to be received by each participant as part of the research protocol.

    2. If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?

    3. Average time taken per intervention (minutes, hours or days)

    4. Details of who will conduct the procedure, and where it will take place

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Consent	1	N/A	5mins	The researcher will gain consent. It will take place at the research site.	Claire Vassallo
Focus group discussions	1	N/A	2hrs	The researcher will conduct these. They will take place at the research site	Claire Vassallo
Individual interview with qualified doctors	1	N/A	1hr	The researcher will conduct these. These will take place either face to face or via the telephone. This is to be negotiated with the participant.	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes   ◉ No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?

---

10. How many research participants/samples is it expected will be recruited/obtained from this site?

15-20participants

---

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Potential participants are current students within the department, and therefore, one will be aware of their suitability for the proposed study. The principle investigator (myself) will approach the participants. This conatact will be via e-mail, with a copy of the invitation letter, consent form and information leaflet. One will not approach potential participants in person.

---

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Claire Vassallo	I have been a midwife for 11years, and am experienced in obtaining consent for examinations and other procedures in the clinical area. I have experience in obtaining patient consent for participation in student

exams as part of my role.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

The participants will be given the contact details of both my supervisors at Northumbria University, whom they can contact to receive more information and advice with regards to this study. The Dean of Undergraduate Medicine at this site is aware of this research project, and can be contacted should the participants wish to do so.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

The participants will be given the contact details of both my supervisors at Northumbria University, whom they can contact to receive more information and advice with regards to this study

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

No

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

All participants are required to have a good command of the English language in order to study at this university.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

Not applicable.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

Due to the nature of the study, it is anticipated that during focus group discussions sensitive issues may arise. If students are upset by any issues, they will be referred to Student Support Team within the Department.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

Dr Colin Chandler and Dr Glenda Cook will be overseeing the project. The Dean of the Undergraduate Department is also aware of the research being conducted.

21. What external funding will be provided for the research at this site?

○ Funded by commercial sponsor

○ Other funding

◉ No external funding

How will the costs of the research be covered?
The costs will be covered by the researcher.

7   83230/290715/6/617/112472/235062

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23. Authorisations required prior to R&D approval

This section deals with authorisations by managers within the NHS organisation. It should be signed in accordance with the guidance provided by the NHS organisation. This may include authorisation by clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers, depending on the nature of the research. Managers completing this section should confirm in the text what the authorisation means, in accordance with the guidance provided by the NHS organisation.

This section may also be used by university employers or research support staff to provide authorisation to NHS organisations, in accordance with guidance from the university.

1. Type of authorisation:
Line Manager

Title Forename/Initials Surname

Post	Clinical Skills Development Manager
Qualifications	RN
	PG Certificate in Education
	Counselling
Organisation	
Work Address	
	th
PostCode	
Work E-mail	
Work Telephone	01772524324
Mobile	
Fax	

Signature: ....

Date: ....

2. Type of authorisation:

Title Forename/Initials Surname

Post
Qualifications
Organisation
Work Address

PostCode
Work E-mail
Work Telephone
Mobile
Fax

Signature:	....
Date:	....

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.

2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.

3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.

4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.

5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.

6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.

7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.

8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.

9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.

10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.

11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.

12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

Signature of Principal Investigator or Local Collaborator:	....
Print Name:	Claire Vassallo
Date:	02/06/2011

—

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northumbria
U N I V E R S I T Y

Ethics Approval Form

School of HCES Ethics sub committee

Proposal Submission Front Sheet

When you submit your proposal for ethical scrutiny please ensure you fill in this front sheet. It will help the committee to process your proposal in a timely manner.

1. **Your Name: …Claire Marie Vassallo…………**

2. **Title of Proposal: …An exploration of how Malaysian Medical Students engage with Western medical ethics………**

   Proposed start date: ……Sept 2011…… Proposed end date: …August 2015………………………….

3. **Reasons for doing this study:**

   Staff funded research   No

   Academic Development: Masters study   No

                                         Doctorate study   Yes

                                         Other, please state   ………………………………..

   Professional interest: Yes / No

4. **If working with children/vulnerable adults, please provide the information below:**

   Are any of your research participants:

- Children   Yes ☐   No ☐√
- Vulnerable adults   Yes ☐   No ☐√

If you have ticked YES for either of above:

Please provide date of CRB check: …In progress………………

Please provide reference number of CRB check: F0064285738…

Is this an **enhanced** CRB check   Yes ☐   No ☐√

Was this obtained through Northumbria University: Yes ☐√   No ☐

If no, do you hold CRB clearance through the NHS Research Passport Scheme: Yes / No

Each research team member responsible for collecting data should hold recent CRB clearance, please confirm:

Name	Standard/Enhanced CRB	Reference	Date
…………………………	………………………… …………………	…………………………	
…………………………	………………………… …………………	…………………………	
…………………………	………………………… …………………	…………………………	
…………………………	………………………… …………………	…………………………	

5. Please answer questions that apply to your situation:

5.1. Who is/are your supervisors for this study…Dr Colin Chandler and Professor Glenda Cook……………………………………………………

5.2. Who are your collaborators in this study…………………………………………………………..

Is any aspect of your study taking place within the NHS?.......Yes...

6. How would you describe this study?

A research project	√

Audit	

Other	

For more information about characterising your study please refer to the guidance available at http://www.northumbria.ac.uk/sd/academic/sches/research/861565/?view=Standard

7. The University has devised a check which will enable you to get a better idea of what level of scrutiny to expect for your study. This can be found at: http://www.northumbria.ac.uk/static/5007/respdf/riskasstool.pdf

At what level would you place your study?

Red   □   Your study is Red if it includes:

•Medicinal Products •Clinical trial •Human tissue* •Animal subjects* •Vulnerable people including children •NHS staff, patients, premises or equipment •Sensitive subjects such as trauma

•Forensic issues •Safety concerns for researcher or participants

If these products have been commercially sourced, or where consent has already been obtained, red light status is unnecessary: only standard governance checks are required in such cases.

Amber   □ √   Your study is Amber if it includes:

•People •Personal data of a living individual •Environmental issues •Commercially sensitive information •Pharmacologically active substance

Green   □   Your study is Green if it includes:

•None of the above

8. About your Proposed Study:

Please complete the following sections detailing the subject, methodology and methods applicable to your proposed study. This will ensure 2 suitable peer reviewers can be selected to review your proposal.

Subject / Field of Study

Please state e.g. Psychology, Aging Studies, Public Health

Education and Ethics

Methodology

Please tick ☑ indicating your methodological approach

Quantitative		Qualitative	√	Quantitative and Qualitative	

Please tick ☑ if you are using a specific methodology / methodologies

You can tick more than one box

Action research ☐   Grounded Theory ☐   Appreciative Inquiry ☐

Survey/ ☐   Case Study ☐   Experimental ☐
Questionnaire

Equipment based measurement ☐   Standardised assessment tools ☐

Other (please state) …………………Constructionist …………

Methods

Please tick ☑ the methods you propose to use in your study

You can tick more than one box

Survey/Questionnaire ☐   Interviews [√]   Focus Groups [√]

Observation ☐   Collaborative ☐
                     Learning Sets

Narrative ☐   Secondary Data ☐

Other (please state)

……………………………………………………………………………………………

9.   Checklist of contents for submission - *Please tick where these have been included*

Proposal (word document)	√
Invitation letters to participants (in appropriate/accessible form)	√
Information sheets (in appropriate/accessible form)	√
Consent forms (in appropriate/accessible form)	√
Questionnaires (validated and/or non validated)	
Topic guides and/or schedules for interviews	√
Topic guides and/or schedules for focus groups	

Any other materials related to data collection

Copies of proposed advertisement material for research

participants, e.g. posters, newspaper adverts, website.

For video, DVD or audio cassettes please provide the printed script.

IRAS Form (electronic submission)

Referees or any other scientific critique already undertaken

10. Please provide correspondence, e-mail addresses and telephone contact number

Miss Claire Marie Vassallo

…………………………………………………….............................

13 Addison Street

………………………………………………………………………..

Accrington

………………………………………………………………………..

Lancashire

BB5 6AG

………………………………………………………………………..

e-mail: ……claire.vassallo@lthtr.nhs.uk…………………………………………

telephone: …………01772 524837…………………………………………………….

11. Please add any other information here that you feel will be helpful for reviewers and which has not already been considered above.

This is a study, looking at how Malaysian medical students engage with Western Medical Ethics. The findings from this study may help in enhancing how ethics is delivered across the medical curriculum, as it becomes more internationalised. A copy of the proposal has been included, giving details on the project.

Supervisor's signature:

Or please ask your supervisor to email julie.blackwell@northumbria.ac.uk to advise whether or not they agree with the submission and with any further comments.

Please forward by email, together with your proposal and other documentation, to Julie Blackwell (julie.blackwell@northumbria.ac.uk)

Research Ethics Committee Approval Letter

Health Research Authority

NR[ ]

Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7831
Facsimile: 0161 625 7299

09 December 2011

Miss C Vassallo
13 Addison Street
Accrington
BB5 6AG

Dear Miss Vassallo

Study title: An exploration of how Malaysian medical students engage with Western medical ethics, with an emphasis on the ethical principle of autonomy

REC reference: 11/NW/0887

The Proportionate Review Sub-committee of the NRES Committee North West - Lancaster Research Ethics Committee reviewed the above application on 08 December 2011.

The Committee has considered and reviewed the project ar[ ] detailed below. However under the new Governance Arrangements for Research Ethics Committees (GAfREC) issued by the UK Health Departments, which came into effect on 1 September 2011, the above study no longer falls within the remit of NHS Research Ethics Committees (REC) and therefore does not require REC review. We suggest that you discuss the matter with the sponsor and lead R&D office, and following that discussion advise the REC how it is intended to manage the project. If the sponsor and R&D office advise that REC approval is no longer necessary, the application can be withdrawn. If it will continue to be managed as research requiring REC review, the opinion given below will remain in place.

The members of the Sub-committee were unclear as to why the application had been submitted for REC review. However the only issue raised was that participation in focus groups will mean that anonymity of participants will not be possible.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion' below).

A Research Ethics Committee established by the Health Research Authority

FIGURE 1

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

| 11/NW/0887 | **Please quote this number on all correspondence** |

With the Committee's best wishes for the success of this project

Yours sincerely

[signature]

Dr **Lisa Booth**
Chair

Email: carol.ebenezer@northwest.nhs.uk

Enclosures:	List of names and professions of members who took part in the review
	"After ethical review – guidance for researchers"
Copy to:	Ms Donna Smith, Pro-Vice Chancellor's Office Northumbria University, Ellison Building, Newcastle upon Tyne, NE1 8ST
	Lin Nelson, Lancashire Teaching Hospitals NHS Trust

A Research Ethics Committee constituted by the Health Research Authority

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Local R&D Approval Letter

RESEARCH AND DEVELOPMENT DIRECTORATE

Tel.   01772 528236
Fax: 01772 523184
Email: heather.adamson@lthtr.nhs.uk
        (R&D Coordinator)

Our Ref: LNHAA

2 April 2012

Miss Claire M Vassallo
Clinical Skills Facilitator
Lancashire Teaching Hospitals NHS Trust
Undergraduate Dept
Royal Preston Hospital

Dear Claire

R&D No: 1551   REC Ref: 11/NW/0887
An Exploration of How Malaysian medical Students Engage with Western Medical
Ethics, With an Emphasis on the Ethical Principle of Autonomy

The above study was reviewed on behalf of Lancashire Teaching Hospitals NHS Foundation Trust by the Research Committee on 27th July 2011. Approval from the Dean of the Medical School at Manchester University was awaited before Trust approval could be given.

I am pleased to inform you we have now received confirmation from Manchester University that they endorse the study. The Trust is therefore happy for this study to go ahead, subject to the conditions listed in the attached document.

This letter acts as proof of NHS Permission to conduct the research project described in the documents submitted for review. Any variations to the protocol must be re-submitted to this Committee and new approval sought. The research project could not start until:

- Ethical approval from the National Research Ethics Service
- The declaration attached to this letter has been signed, dated and returned to the Research Directorate;
- Funding arrangements in place

Any failure to comply with these requirements will result in action being taken under the Lancashire Teaching Hospitals NHS Foundation Trust Policy for Fraud and Misconduct in Research.

List of documents reviewed and approved:

Consent form
Indemnity
Info sheet
Invitation letter - app A
NhsRdForm_ReadyForSubmission
REC_Approval_9-12-11
RecForm_ReadyForSubmissionoctoberv2
Research Proposal for ethics

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Appendix B: Participant Materials

Consent Form Template

CONSENT FORM

Student Participant

Project Title: An Exploration of how Malaysian medical students engage with Western Medical Ethics

Name of Researcher: Claire M Vassallo

I …………………… (print name)

Yes   No

confirm that I have read and understand the information sheet

for the above study and have had the opportunity to ask questions,

which have been answered to my satisfaction

☐   ☐

understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, and my rights will not be affected

☐   ☐

am aware that if I withdraw, the information recorded in discussions

may still be used, due to the nature of the data collection method.

☐   ☐

understand that my personal information will not be
dislcosed to outside parties and it will be held in the ☐ ☐
strictest confidence.

agree to the use of direct quotes in the publication of this study ☐ ☐

agree to the use of anonymised quotes in the publication of this study ☐ ☐

agree to the interview/focus group discussion being audio recorded ☐ ☐

agree to take part in this study ☐ ☐

Signed……………………………… Date ………………… (Participant)

Signed………………………………. Date………………… (Researcher)

1 Copy for the participant
1 Copy to be kept on file

Project Information Sheet for Participants

-

PARTICIPANT INFORMATION SHEET

In order for you to take part in this study, you must first understand why this research is being conducted and what the process involves. It would therefore be beneficial if you could take some time to read the information provided on this sheet. If you require more information or clarification on any aspects of this study please do not hesitate to contact me on :

[university e-mail] or telephone 01772 52 4837 (work)

What is the purpose of this study?

This project aims to explore how Malaysian students engage with Western medical ethics, whilst studying at university in the United Kingdom. This is an important topic, as it will provide information that will aid in the developing of the ethics component of the medical course curriculum, in order to address the needs of the students. It will allow the gaining of an understanding of the differences in ethical principles which exist within the Malaysian students.

Why have you been selected?

I am asking all 5th year Malaysian students who have joined the MBCHB medical course in the 3rd year of the studies to take part.

What will happen if you take part?

You will be asked to take part in a focus group discussion with approximately 4 or 5 students from the course. The discussions aim to focus on issues such as "the differences between Western healthcare ethics and those adopted in Malaysia", "does the ethics teaching at this medical school meet your learning needs for this topic;" "is it relevant and does it provide you with the tools to make clinical decisions."

These discussions will not be rigid and you will be encouraged to discuss ideas freely. The sessions will be recorded but your personal details will remain confidential, and you will be required to sign a consent form as written evidence of your acceptance to take part.

Once all the focus group discussions have taken place, the data will be analysed, recurring themes extracted and coded. You may need to be contacted and interviewed in order to clarify any issues that have arisen from the data collection.

Do you have to participate?

No, there is no obligation to take part

Will your participation remain confidential?

All information collected will be held in the strictest confidence and discussions will be coded so that your personal details cannot be identified. All data will be stored securely and kept for 5 years after the study has been completed and then disposed of securely.

Confidentiality will only be breached should you disclose any information that may require notification to a professional body e.g. in instances of medical malpractice

There may be instances when the discussions may result in sensitive ethical issues pertaining to patient care being raised. This may be upsetting for some participants. If this does occur, the interviews/discussions would stop and you may wish to cease participating. If you require any additional support, provisions would be made for you to be referred to the appropriate member of staff/occupational health/staff support.

What happens once the study has reached its conclusion?

At the end of the study the results will be written up as a thesis and submitted to the University of Northumbria. I also hope to have these published in educational or medical ethics journals, or present them at conferences. I also intend to produce a summary of results which will be available to all those who participated. Once again, your personal details will not be identified in these.

Who is supervising the research?

This study is part of a PhD and is being supported and supervised by the University of Northumbria. Consent has also been gained from the University of Manchester and the Hospital Dean of the respective hospital trusts.

Who has provided ethical approval for this study?

Ethical approval has been sought from the [university researcher studies at], [University attended by the medical students in UK], [local hospital Trust] and from the National Research Ethics Service (NRES).

Other contacts?

If you have any queries of concerns you may contact my two principle supervisors

Dr Colin Chandler   [university e-mail]

Dr Glenda Cook   [university e-mail]

Appendix C: Presentations and Conferences

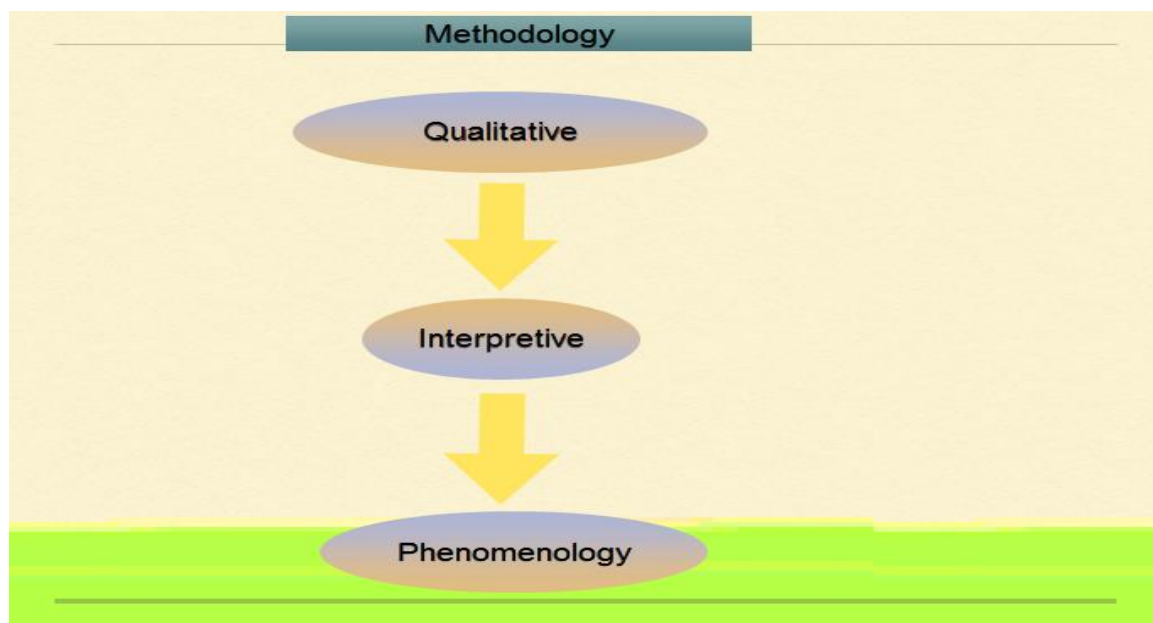Presentation at Northwest Student
Presentation at Research Conference 2016

An Exploration of how Malaysian Medical Students on a Partner Medical School Program, Understand Ethical Dimensions of Practice

Claire Vassallo RM BA(Hons) MA PGDip Higher Ed

AIMS and OBJECTIVES

to explore how this population understand ethical dimensions of practice

1) to explore how Malaysian medical students, develop understanding of the ethical dimensions of practice

2) to investigate factors that may influence or impact the students' understanding of ethical dimensions of practice

3) explore the students' ability to identify the application of the ethical dimensions of practice in clinical practice within diverse cultural contexts

LITERATURE REVIEW

Substantial amount of literature

Only 5 pieces of research

Main Topics Discussed
Culture/Global Applications
Curriculum

Culture and conflict between theory and practice
Fuscaldo et al (2010)

Language Barriers
Ypinazar & Margolies (2004)

Content
(Miyakasama et al 1999 and Haque 2013)

Teaching Models
(Yali et al 1997)

Methodology

Qualitative

Interpretive

Phenomenology

Methods

Sample population

Malaysian Medical students
Direct Entry
Year 5

Data Collection

Semi-structured focus group
and individual interviews

Audio Recordings

Data Interpretation

Adaptation of Hycner's
(1985) 15 steps model
Thematic Analysis

FINDINGS

How they develop an understanding

- Through observation of how ethical dimensions are applied to practice
- By internalising their observations with their own moral compass
- Observation within various cultural settings

FINDINGS
INFLUENTIAL FACTORS

- How patient needs are met

- Respecting patient rights

- Cultural perspectives

- Beliefs and Values

FINDINGS
STUDENTS ABILITY TO IDENTIFY ETHICAL DIMENSIONS OF PRACTICE

Consent

Confidentiality

Doing no harm

Privacy and Dignity

Shared Decision Making

Sharing Information

ANY QUESTIONS?

THANK YOU!

Appendix D: Literature Review Table

Source	Year	Author	Title	Purpose/Type of Research	Sample	D
RESEARCH ARTICLES						

* BMC Medical Ethics	2004	Ypinazar, V.A. Margolis, S.A.	Western Medical Ethics Taught to Junior Medical Students Can Cross Cultural and Linguistic Boundaries	To investigate if Arabic speaking students studying medicine in an Arab country (Qatar) would correctly identify some of the principles of Western medical ethics.	62 1ˢᵗ year medical students	A qu sing stud invo teac ethi stud asse thei iden prin thro writi writt
* BMC Medical Ethics	2004	Ypinazar, V.A. Margolis, S.A.	Western Medical Ethics Taught to Junior Medical Students Can Cross Cultural and Linguistic Boundaries	To investigate if Arabic speaking students studying medicine in an Arab country (Qatar) would correctly identify some of the principles of Western medical ethics.	62 1ˢᵗ	A

Eubios Jouran of Aisan and International Bioethics	1997	Yali, C	**The Teaching of Medical Ethics in a Beijing Medical University**	Research Paper based on a survey critiquing the model used to teach medical ethics in a Chinese medical university.	107 medical undergr aduate students (exclude d Pharma cy students)	An e of ef teac look inter stud takir med cour and takir cour look metl to te how were by tl stud
Eubios Jouran of Aisan and International Bioethics	1997	Yali, C	**The Teaching of Medical Ethics in a Beijing Medical University**	Research Paper based on a survey critiquing the model used to teach medical ethics in a Chinese medical university.	107	An e of ef teac

	2010	Fuscaldo, G Russell, S Delany, C	**Enhancing Cross-Cultural Understandings of Ethical Issues in Medical Education**	Research paper based on a study carried out by the authors. It focuses on exploring how students taught the 4 Principles Approach find the suitability for use in a Malaysian clinical area with suggestions on how this understanding can be enhanced.	40 3rd year medical students who had conduct ed early clinical years in Australi a and were in clinical years in Malaysi a.	A qu sing stud Ther anal used iden then stud resp
Australian Journal of Bioethics						

	2013	Salam, A Haque, M Islam, Z Helali, A, M Yousuf, R Yesmin, F Alattraqchi, A.G. Mahadeva-Rao U.S	**Comparative study of professionalism of future medical professionals among three private medical colleges in Bangladesh**	Research paper I	332 Year 3 and 4 students on a MBBS medical program at private medical colleges in Banglad esh	Cros sect mixe meth sing stud 5 po scal whic stud wou the elem prof m
Asian Journal of Pharmaceu tical and Clinical Research						

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Medical Education	2011	Elit, L Hunt, M Redwood-Campbell, L Ranford, J Adelson, N Schwartz, L	**Ethical Issues Encountered by Medical Students during International Electives**	Research paper focus on the challenges relating to ethical issues that students encounter when taking an elective placement in countries with low resources	Purposive sample 12 medical students who had returned from International Health Elective (IHE)	Sing stud
	2011	Elit, L Hunt, M				

Universidad de Chile	Accessed April 2016	Drane, J Roth, R, B.	**Medicine and the possibility of a universal ethics**	This is a paper discussion the move towards a mor[...] such as overcoming cultural differences through m[...] it case of point in order to discuss the need for a u[...]

	2001	Gatrad, A.R Sheikh,A	**Medical Ethics and Islam; Principles and Practice**	This opinion paper discusses the need for doctors i awareness in order to deliver culturally sensitive ca teaching relating to medical ethics.
British Medical Journal				

Academic Medicine	2005	Rodriguez Del Pozo, P Fins, J.J	The Globalisation of Education in Medical Ethics and Humanities:Evolving Pedagogies at Weill Cornell College in Qatar	Discussion Paper based on an evaluation of the im students.
				Preclinical Medical students
				Evaluation and feeback of an introductory course o
				Feedback was obtained using a Likert scale
				There were no details of the number of students wh and discussion of various areas of the biopsychoso

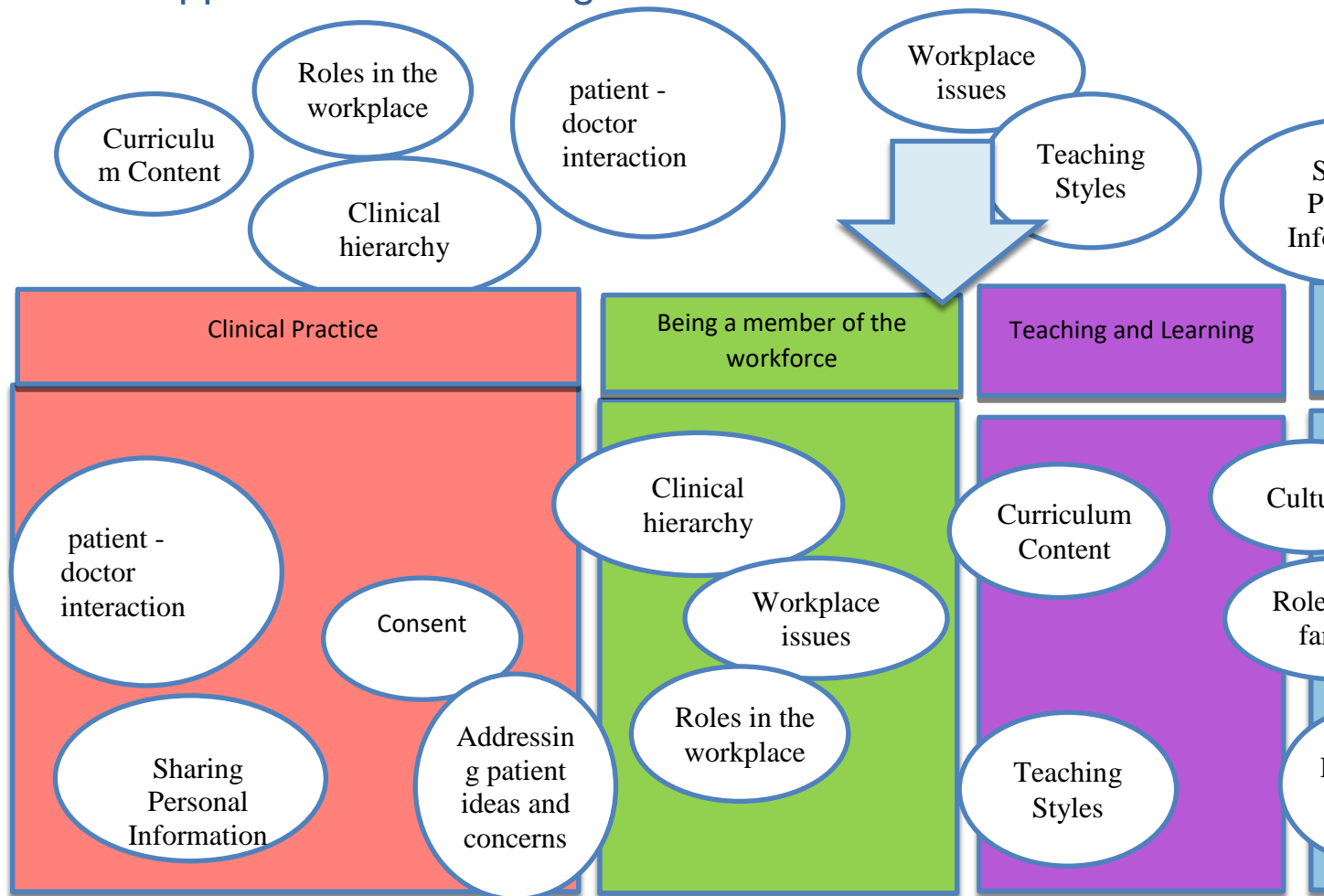| *Society for Academic Emergency Medicine*	2012	Iserson K.V Biros M.H Holliman C.J	**Challenges in international medicine;** **Ethical dilemmas, unanticipated consequences and accepting limitations**	Case discussion paper whereby the authors worked 4 clinical cases using the 4 domains of: Clinical Practice Systems and systems development Teaching Research Analysis of 4 clinical using the four domains. Demonstrated a need to modify "Western" respons cultures and the need for cultural sensitivity to achi

	2012	White, M	Developing Ethical Awareness in Global Health: Four Cases for Medical Educators	This article discusses the increasing interest in glob
Developing World Bioethics		Evert, J		and junior doctors which has led to an increase of s
				there are disparities in the courses delivered. This
				tool with each scenario presented capturing comm

	2004	Weber, Z	**Working Towards Culturally Sensitive ethical practice in a multicultural society**	This article focuses on the daily challenges faced by within the patients in society. It proposes that pract multicultural society is essential for good practice. sensitive ethical practice guidelines within the cont cultural sensitivity of existing codes of ethics and 2
Journal of Practice Teaching				

	2010	Doering, O	**Teaching Medical Ethics in China; Cultural, Social and ethical Issues**	This discussion paper was based on the designing a discussion was based on the feedback provided by difficulties encountered by foreign lecturers trying t students perceive the teachers as authoritative figu students' perceptions of learning as this was an int teacher says or what is in books. The experience of find new ways of teaching medical ethics in their ov
Eubios Ethics Institute				

	2014	Falkenheimer, S.	**Medical Ethics Education in the US and around the world** Exploring the status of global bioethics standards	This article poses the issue of how advancing techn[...] professionals have an education in bioethics. It loo[...] bioethics programs across the world. The countries [...] Canada, Australia, New Zealand, Pakistan and the [...] incorporate such programs within existing healthca[...] Christianity on bioethics around the world.
Christian Medical and Dental Associations				

Appendix E: Clustering of codes

Roles in the workplace

Curriculum Content

patient - doctor interaction

Clinical hierarchy

Workplace issues

Teaching Styles

Clinical Practice

patient - doctor interaction

Consent

Sharing Personal Information

Addressing patient ideas and concerns

Being a member of the workforce

Clinical hierarchy

Workplace issues

Roles in the workplace

Teaching and Learning

Curriculum Content

Teaching Styles

Appendix F: Interview Guide

Interview Guide		
1) Introduction	Welcome the participant Thank the participant for attending	
2) Consent and Ground rules	Ensure participant has read the information sheet Ensure consent form is signed Re-iterate the purpose of the study and role of researcher and participant to ensure understanding Ground rules with regards disclosure of professional issues or action should the researcher feel the participant needs support	
	Ice-breaking opening question to gain background and insight into participants "Tell me about the schools you attended in Malaysia?" "Tell me about university…. What you covered….. Teaching methods….. Placements?"	
	Can you tell me a little bit about your learning of ethics? Have you seen ethical issues in the clinical area? Ethical principles applied in the clinical area?	

	Can you tell me about your experiences of clinical practice/hospital areas in Malaysia?	
Questions based on pre-reading	I have read an article/learnt about… Can you tell me about this?	
Exploratory questions	Can you tell me a little bit more about that? Could you explain that for me? Is there anything else you can tell me? How do you mean when you say….? You've spoken about…. Can you elaborate on that?	

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