Education in Medicine Journal

ORIGINAL ARTICLE

Navigating Feedback in High-Power Distance Culture: Insights into Medical Students' Feedback-Seeking Behavior in Clinical Settings

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ABSTRACT

Feedback-seeking behavior (FSB) is the proactive act of seeking, interpreting, and applying feedback to improve performance. The literature highlights the importance of feedback in fostering learning and development, particularly in clinical settings. However, high-power distance and the hierarchical structure of medical education in Indonesia may challenge students' willingness to seek feedback. This study aims to explore clinical students' FSB and identify the factors influencing students' FSB in a clinical setting. This qualitative study employed a phenomenological approach. Data were collected through six focus group discussions with 43 clinical clerkship students and five interviews with five clinical teachers representing six regions of the Association of Indonesian Medical Education Institutions. Thematic analysis used the Steps for Coding and Theorization (SCAT) approach to identify key themes and sub-themes related to FSB. The thematic analysis identified four key themes related to FSB among clinical clerkship students: methods (direct inquiry, indirect inquiry, and monitoring), frequency (often to peers and residents, rare to teaching staffs), signs (a positive approach to any feedback) and outcomes (improved performance, enhance learning, increase adaptability, and manage impression). Factors influencing FSB were categorized into three main areas: seeker antecedents (motivation, dispositional, cognitive, and emotional variables), target antecedents (target professions, credibility, characteristics, busyness and time, and mood), and context antecedents (relational, environmental, and structural context).These findings highlight the complex interplay of various factors that influence clinical clerkship students' feedback-seeking behavior and emphasize the importance of addressing these factors to promote a culture of feedback-seeking in clinical education.

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INTRODUCTION

Feedback plays a critical role in enhancing learners' performance (1,2). According to Rees and Shepherd (3), feedback enable learners to monitor their progress, identify areas for improvement and engage in self-assessment. In the context of medical education, Bose and Gijselaers (4) emphasize that feedback is essential not only for understanding medical knowledge but also for navigating clinical environments that involve multidisciplinary collaboration and clearly defined professional roles. Moreover, seeking feedback in clinical learning environments contributes significantly to learners' professional development (5,6). Despite its importance, much of the literature on feedback in medical education portrays learners as passive recipients of feedback. This perspective often emphasizes the content of the feedback and the strategies employed by educators, while paying relatively little attention to the active role of learners in the feedback process (5,7,8). However, it is widely understood that individuals naturally seek information about their performance to improve and reach specific goals (9). This proactive behavior, referred to as feedback-seeking behavior (FSB), is defined as the deliberate effort to obtain, interpret, and utilize performance-related information to achieve predetermined goals (10).

FSB was first introduced by Ashford and Cummings in 1983 to describe the actions of employees who actively seek feedback in an organizational settings (11). Since then, the concept has been extensively developed and applied in studies focusing on employees and workplace behavior (12,13). However, FSB is also highly relevant in educational contexts, as learners share similar goal orientations and levels of self-awareness with employees in organizational environments (14). Effective FSB is an important strategy for adaptation, learning and performance enhancement. Individuals who regularly seek feedback are better equipped to identify performance gaps and environmental expectations, enabling them to make adjustments that align with desired standards. Access to feedback not only supports skill development—particularly in areas such as creativity—but also helps individuals gain new perspectives on their ideas. Moreover, those entering new environments are likely to integrate more smoothly if they actively seek feedback because this facilitates a clearer understanding of their roles in the given context (9).

Clinical settings are characterized by learning and assessment processes that occur in the workplace, involving real patients, numerous unpredictable variables, and significant time constraints (15). Clinical learning is inherently workplace-based and grounded in an experiential learning cycle, which is most effective when followed by processes of self-reflection and feedback. Providing timely, specific, and nonjudgmental feedback after direct observation of learning activities has been identified as a valuable strategy for enhancing workplace-based learning (16).

However, several studies report that many students express dissatisfaction with the feedback they receive in clinical learning environments (5,17,18). A common concern is that educators rarely engage in direct observation or provide feedback during clinical activities (19). Given the recognized benefits of feedback, alongside the challenges typical of clinical learning contexts, students should be encouraged to adopt an active role in seeking feedback as an external source of information to support accurate self-assessment and performance improvement.

Contemporary definitions of feedback emphasize the learner's responsibility in interpreting feedback and utilizing it for self-improvement (20). A key principle in current feedback practices is the active role of learners and their follow-up on feedback received. However, this shift in emphasis has not been paralleled by significant development in the literature on medical students' FSB (7). Research on FSB offers a valuable lens through which to explore students' active engagement in the feedback process (10).

Cultural norms and values significantly influence both feedback processes and FSB (21,22). According to Hofstede's cultural dimensions theory (23), Asian countries, including Indonesia, tend to score high on the power distance index. Raymond and Choon (24) categorize Singapore, Hong Kong, China, South Korea, Malaysia, Indonesia, and Vietnam into a single group because these countries have similar cultural characteristics, particularly collectivism and high power distance. These cultural traits shape student learning styles and strategies, promoting teacher-centered approaches, strong respect for hierarchy and status, and a preference for harmonious classroom environments where students rarely ask questions (24,25). In such contexts, learners speak only when requested by the teacher, avoid confrontation, and view the teacher as a respected authority figure. Individuals raised in this cultural setting are highly attuned to others' judgments about their behavior, including FSB. As a result, the hierarchical nature of medical education in high-power-distance cultures can lead to student passivity and hesitancy in seeking feedback, particularly from superiors (14,24–26). This reluctance is often driven by a fear of negative evaluation and a desire to maintain a positive self-image (22).

Research on FSB in medical education has predominantly focused on clinical settings, especially in the context of residency education (4,5,18,27). This focus is largely due to the nature of clinical learning environments, which naturally facilitate opportunities for feedback-seeking (9,28,29). However, there is a lack of research specifically examining FSB among clinical clerkship students. Pinasthika and Findyartini (30) found that supervisor, student, and environmental factors can influence the FSB of final-year undergraduate medical students. McGinness et al. (31) several determinants of FSB during clinical attachments, including environmental factors, individual student attributes, and the quality of teacher–student relationships. Despite these insights, there remains limited understanding of clinical clerkship students' FSB in hierarchical, high-power-distance cultural contexts. Therefore, further exploration is needed. This study aims to explore the FSB of medical students and the factors influencing them in a clinical setting, drawing upon Ashford et al.'s current theoretical model of FSB (13).

METHODS

Study Design and Participants

This qualitative study employed a phenomenological approach, which was chosen to explore and describe FSB based on the lived experiences of clinical clerkship students. FSB is a complex, subjective process shaped by students' perceptions, motivations, and contextual factors. The phenomenological approach allows for a deep exploration of how students experience, interpret, and give meaning to their FSB, which aligns with the study's aim of uncovering the essence of that experience (32). The study was conducted in clinical settings at six public faculties of medicine in Indonesia, each representing one of the six regions of the Association of Indonesian Medical Education Institutions. All selected institutions held an A or superior accreditation status, had established residency training programs, and had implemented learning and assessment methods that facilitate feedback. These criteria were intended to ensure a baseline of institutional quality and comparability across sites, particularly in terms of feedback culture and clinical teaching infrastructure.

Data were collected through focus group discussions (FGDs) with clinical clerkship students. Maximum variation sampling was used to select clinical clerkship students based on gender, grade point average in the preclinical phase, and the origin of the region proportionally. Interviews with clinical teachers were conducted as a form of data triangulation and data collection techniques. In-depth interviews were also conducted with one clinical teacher in each institution who had a working

period of 5–10 years, had attended clinical teacher training programs, and was actively involved in the learning process at the clinical stage for a minimum period of the last two years. The 5–10-year range was chosen to include educators who are sufficiently experienced in clinical teaching while still being closely engaged in supervising and providing feedback to students on a regular basis.

Data Collection

Data were collected between August and October 2023. FGDs and interviews were conducted using a virtual meeting platform until the data were saturated while conducting an iterative analysis. In-depth interviews were conducted with five of the six clinical faculty members initially selected for data triangulation. One clinical teaching staff member did not respond to be an informant when contacted by the author. Data saturation was reached after the fourth interview because there was no new code or theme generated (inductive thematic saturation) (33). Therefore, the authors decided to only analyze the data from five interviews. The first author (DO) acted as the moderator and took field notes for all FGDs and interviews. A short list of general open-ended questions was used to guide the discussions. These questions were developed based on a review of the relevant literature, discussed among all authors, and revised accordingly. The questions were set to explore (1) students' and teachers' perceptions of FSB in clinical settings and (2) factors affecting clinical clerkship students' FSB. The list of questions is presented in Figure 1.

For students:
1. What drives students in seeking feedback?
2. What is holding students back in seeking feedback?
3. What are some of students' considerations when choosing targets for seeking feedback?
4. Usually, when, and where do students look for feedback?
5. How do students seek feedback?
6. What is your perception if clinical students sought feedback to clinical teacher?
7. How do you perceive the current clinical medical students' feedback-seeking behavior?
8. Is the clinical learning environment supportive for student to seek feedback?

For teachers:
1. Have you ever found students who are actively asking for feedback?
2. Can you tell us about your experience when there are students who ask for feedback?
3. Under what conditions do students usually ask for feedback?
4. In your opinion, what factors motivate a student to seek feedback?
5. In your opinion, what are the factors that influence a student to actively seek feedback?
6. What do you think about the current clinical learning environment? Does it support feedback seeking?

Figure 1. The List of Questions for FGD and Interview

Data Analysis

FGDs and interviews were video- and audio-recorded and transcribed verbatim. The text data of the FGDs and interviews were analyzed independently by the first author (DO) using the Steps for Coding and Theorization (SCAT) approach (34). DO identified noteworthy words or phrases in the text, formulated the relevant concepts from them, and then constructed the relevant subthemes based on each word or phrase. Following the thematic analysis, each subtheme obtained using the SCAT approach was mapped onto the FSB framework (13). After the initial thematic analysis, subsequent discussions were held by the research team for the extraction and finalization of themes and subthemes. Member checking was conducted by confirming the results with representatives of the students and teachers involved in this study, especially when there was a difference of opinion among the authors about the coding or themes, or when the audio or video was unclear due to connection issue.

Ethical Considerations

The Research Ethics Committee of the Faculty of Medicine at Universitas Indonesia granted ethical permission under reference number KET-954/UN2.F1/ETIK/PPM.00.02/2023. Participation in the study was voluntary, and all individuals provided informed permission. The study team guaranteed data confidentiality by treating it properly during the collection and analysis phases.

RESULTS

This study involved 43 students and five clinical teachers. FGDs with clinical clerkship students were conducted six times, with participants from six medical faculties representing the six regions of the Association of Indonesian Medical Education Institutions. Meanwhile, individual interviews with clinical teaching staff were conducted five times, involving participants from five medical faculties representing five of the six regions, as a form of data triangulation. Quotations are presented with corresponding FGD or interview numbers and participant codes (S = students, CT = clinical teachers) for reference. The participants in the FGDs and interviews are listed in Table 1.

Table 1. Characteristics of FGDs participants and interviewee

Participants	Number of Participants	Gender		Symbols for participants
		Male	Female	
FGD				
• Students from region 3	10	5	5	S_FGD1
• Students from region 1	6	3	3	S_FGD2
• Students from region 4	7	4	3	S_FGD3
• Students from region 6	7	4	3	S_FGD4
• Students from region 5	7	3	4	S_FGD5
• Students from region 2	6	4	2	S_FGD6
Interview				
• Teacher from region 3	1		1	CT1In1
• Teacher from region 1	1	1		CT2In2
• Teacher from region 6	1		1	CT3In3
• Teacher from region 5	1		1	CT4In4
• Teacher from region 4	1		1	CT5In5

Note: FGD: focus group discussion, In: Interview, S: Student, CT: Clinical teacher

The themes and subthemes obtained are grouped by referring to the framework of the FSB model in workers, which consists of three main elements: antecedents, FSB and outputs (7,13). Based on thematic analysis from the FGDs of clinical clerkship students and interviews with clinical teaching staff, it was found that there are four themes related to clinical clerkship students' FSB and three related to factors influencing FSB.

The clinical clerkship students' FSB consists of four themes: methods, frequencies, signs and outcomes. Clinical clerkship students employ various methods of seeking feedback, including direct inquiry, indirect inquiry, and monitoring. While students frequently seek feedback from friends and residents, they are less likely to seek feedback from teaching staff. When compared to previous research on FSB (4,7,9,10), these results add to the information that medical students also use indirect inquiry methods in seeking feedback in clinical settings by directing the conversation toward an area where the students are interested in receiving feedback. In addition, the frequency of feedback-seeking is also influenced by the profession of the feedback provider. Clinical clerkship students have a positive attitude toward feedback, regardless of its type. They value the intent behind the feedback

and the manner in which it is conveyed. Additionally, seeking feedback can contribute to improved performance, enhance learning, and increase adaptability and impression management. Themes, subthemes and quotations from clinical clerkship students' FSB can be seen in Table 2.

Table 2. Theme, subthemes and quotations of clinical clerkship students' FSB

Theme	Subtheme	Quotations
Method	• Direct inquiry	*"I asked directly to the … doctor in charge…, usually for… to… asked if it was true or not." (S10-FGD1)*
	• Indirect inquiry	*"If we ask openly, like… 'can we ask for feedback from doctors regarding this performance…?' Maybe there is no one who ask blatantly like that. But maybe indirectly, like we come to the doctor ourselves to ask something or like asking after the exam, how was my exam like." (M3-FGD2)*
	• Monitoring	*"I also go to the supervisor often, but more like observation, … it's more like just looking at it, like when in the endoscopy room or maybe like when in the operating room." (M4-FGD2)*
Frequency	• Frequently seek feedback from friends and residents	*"I'm looking for feedback…, more often to my friends because I might feel more comfortable…" (M2-FGD3)* *"But if I want to ask for feedback directly from the teachers, I just go to the residents more often. I have never asked the supervisor." (S6-FGD3)*
	• Less likely to seek feedback from teaching staff	*"I don't ask feedback to the doctor too often…" (S2-FGD3)* *"Woah almost… almost none. Yes, in my opinion the students tend to be passive. They tend to wait for us to give, that's it." (CT4In4)*
Sign	Positive attitude toward any type of feedback	*"It doesn't matter whether the feedback is positive or negative. The important thing is how to do it right… the doctor taught the right thing to us" (S10-FGD1)*
Outcomes	• Improved performance	*"If I get positive feedback or a good response, I will be more confident. It continues to be more… it motivates me for doing the skills more often… the feedback encourages me for doing it again…(M2-FGD1)*
	• Enhance learning	*"Negative feedback is also necessary. It is necessary for students to assess himself so that… that mistake is not repeated." (M4-FGD1)*
	• Increase adaptability	*"Feedback is very important to guide us, especially later to become a clinician, ee… a clinician who will face the patient. So that when we will face patients later, not only are we clinically skilled, but with feedback…, our mental … can also be trained." (M1-FGD4)*
	• Impression management	*"That's a formality. in the case management session, that's common and every time they finish their presentation, they must ask feedback. Is that included in the effort to seek feedback?" (CT1In1)*

The factors influencing FSB consist of three themes: seeker antecedents, target antecedents, and contextual antecedents. Seeker antecedents such as motivation, dispositional variables and cognitive factors play a crucial role. Students' motives, learning goal orientation, and cognitive variables such as

benefit and risk influence their likelihood of seeking feedback. Target antecedents also play a vital role. Students are more likely to seek feedback from credible and approachable individuals, such as residents and physicians, who are perceived as knowledgeable and supportive. Antecedents, such as relational, environmental, and structural contexts, further shape FSB. Students are more likely to seek feedback in casual interactions with peers or residents and in environments that foster a supportive and collaborative atmosphere. The results provide more detailed insights into the motives of feedback seekers, the professional backgrounds of feedback providers, and the influence of time and environmental context on FSB. Previous studies have identified three main motives: learning, image, and ego motives (9,35,36). In contrast, this study expands on these by identifying four distinct motives (9). Additionally, it highlights that medical students seek feedback not only from faculty but also from residents and other health professionals. Their FSB is also shaped by whether the learning session is formal or informal, as well as by environmental factors such as the type of teaching hospital, patient load, and the size of the student group. The themes, subthemes and supporting quotations related to factors influencing FSB are presented in Table 3.

Table 3. Theme, subtheme and quotations of factors influencing FSB

Theme	Subtheme	Quotations
Seeker Antecedents	*Motivation variables*	
	• Self-assessment motives	*"The other factors, apart from feeling that it is still lacking, mainly, it is also for self-evaluation. Suppose I feel, "oh this is me… I think it's okay enough", but I don't know what it is like in the eyes of my friends or supervisors, whether we are indeed good enough or it turns out that we still have shortcomings." (S5-FGD3)*
	• Self-improvement motives	*"I just want to ask, whether… whether what I did was right or whether there were things I had to correct." (S1-FGD4)*
	• Self-enhancement motives	*"Sometimes there are also those who do, … some friends who are indeed looking for feedback, actually not for feedback purposes, but there is… for (think) to look good in front of others." (S1-FGD2)*
	• Self-verification motives	*"…Is it really the right time to look for feedback? Because I think that time is right and the moment is also right, the supervisor remembered me and the case was the same, so I asked him for feedback." (S1-FGD5)*
	Dispositional variables	
	• Learning goal orientation	*"So, it depends on how we respond, right, and for me personally, all the feedback is positive…. Even though like being scolded, even though this is the way it is, I still think yes, this is indeed the time for me to learn like that." (S9-FGD1)*
	• Prove performance goal orientation	*"I dared to ask for feedback because ee… at that time, indeed, if I looked more at the conditions at that time, the situation at that time, whether it was really the right time to look for feedback or not, because I think the time was right and the moment was also right, he remembered me and the case was the same, so I asked him for feedback." (S1-FGD5)*

	• Avoid performance goal orientation	*"I don't feel like I have enough knowledge, so for example, I have actually learned, but it seems that when I go to the patient, it's different... The fear is because eee... I feel like I haven't learned that. So, for example, I have learned, but when I meet a patient, the patient has a different case from what I have learned. I mean, we can't predict, yes, maybe sometimes there is something that can be predicted... So, in the end, I feel like, I haven't reviewed it yet, so it's like I'm afraid of being scolded." (S3-FGD6)*
	Cognitive variable	
	• Benefit	*"We can evaluate whether our procedural techniques are correct or not, or maybe in terms of understanding, it is appropriate or not." (M1-FGD6)*
	• Presentation risks	*"I'm a bit scared to ask questions like..., how if I can't answer if I was asked back, how is it, oh my gosh, I'm confused..."(S4-FGD4)* *"But sometimes there are also some times ee... I feel... Not confident. From my experience, what I feel is fear... I'm afraid if... Ah, this is such a silly question... Questions that are meant not to be too necessary. Students like me should already understand that" (S1-FGD4)*
	• Ego risk	*"To be honest, the most inhibiting factor is more the factor I told you earlier, the fear of being scolded, actually." (S3-FGD6)*
	• Effort risk	*"I also sometimes think first about whether I should ask this person or not. Because I'm afraid, for example, if I ask for feedback, he will not necessarily give constructive feedback." (S4-FGD5)*
	Emotional variables	
	• Mood	*"But sometimes it is also true that if for example you are tired or have a task the next day, you are also lazy to look for feedback." (S1-FGD6)*

Target antecedents	• Target professions'
	  o Physician teaching staff
	  o Resident
	  o Friend
	  o Nurse
		"...Usually, if for example you have finished reading or maybe there is something you don't understand, ee... to improve it, to know more about it, you usually want to find out more, whether it's from a resident doctor, or ask the supervisor doctor. Maybe when it is related to skills, maybe ask more to nurses..." (S4-FGD2)

	• Target credibility	*"Because he is already at the level of a doctoral specialist, so I consider the credibility of him to be good enough for me to explore his knowledge" (S5-FGD4)*
	• Target characteristics'	*"The reason I dared to ask immediately at operating room at that time, because it happens that this supervisor is very close and very friendly to students so I was provoked to ask directly." (M1-FGD4)* *"The lecturer is easily angry, emotional and others. Maybe that's what makes students hesitate to ask." (D1W1)*

	• Busyness and time	*"There is another department whose supervisor is busy… The time is also limited." (M3-FGD2)* *"Afraid to ask because the doctor is busy" (D1W1)*
	• Mood	*"Because I was afraid that the doctor would not welcome me or that he was in a bad mood, I just didn't know the situation. So, I'm afraid to ask, … I'm afraid to find out" (S5-FGD2)*
Context antecedents	*Relational context*	
	• Casual interaction	*"Because the interaction is more casual with the residents, so that, the feedback, the way is better, smoother." (S3-FGD1)*
	• Personal closeness	*"We also usually prefer to ask for feedback if it is with a resident or a supervisor we already know." (S5-FGD6)*
	Environmental context	
	• Another friend asked	*"He was given good feedback, so I think I should use this opportunity to ask questions about things I don't know. It also happens that he asks about material that I don't understand, so I became even bolder to ask because I saw that he got quite good feedback." (S4-FGD4)*
	• Small group interactions	*"With the supervisor, at least the activities are in a small group, for example, like… in polyclinic, there is one doctor, one small group. Well, that's because of possible interaction with fewer people, so you can get feedback as well."(S2-FGD1)*
	• Network teaching hospital	*"If at the network teaching hospital, because there are fewer residents, we can get more opportunities, including for seeking feedback and… at the time of handling patients…" (S1-FGD5)*
	• Primary teaching hospital	*"If it is from AH Hospital (primary teaching hospital), what I feel is from the supervisors, maybe because the supervisors are busier and also…, from here I see that the patients are diverse and more complicated case, so we are more … it's hard to … if you want feedback that asks, sometimes the doctor also thinks that this is not our competence." (S10-FGD1)*
	• Patient load	*"Oooo today is the patients was crowded, hectic, actually not worth it… if we throw the feed… Ee… Um… asking for feedback, … for an actual action we did before" (S1-FGD2)* *"So, if for example, we have a lot of time, not so many patients, maybe I'll supervise you here." (CT2In2)*
	• Size of the student group	*"Sometimes I admit that I also don't have time to give feedback, for example: there are a lot of patients, the number of students is large, like now 25, 27 people, so there are many students" (CT1In1)*
	Structural context	

•	Hierarchical structure	*"The gap is very prominent between Prof or other supervisors with us as the students… so we approach the most to the closest level to us, for example, residents… Those are our efforts to minimize gaps" (S3-FGD3)*
		"There is also a station which rule is that students are prohibited from directly contacting supervisors and must ask through the resident first. And as I said earlier, there are some students who are hesitant to ask. For example, if he has to ask a supervisor, he must collect questions and filter them first through the resident, he cannot directly ask the supervisor. And some stations implement such a system." (S4-FGD5)
Cultural context		
•	Fear of disturbing	*"From my point of view, I am personally reluctant or unpleasant to ask questions, because fear of disturbing the time of the supervisor." (S3-FGD4)*
•	Because was not asked	*"… There was no question from the supervisor or the resident or the nurse, nor did we ask for feedback." (S2-FGD2)*
•	Usually notified immediately	*"Because usually if something is wrong, the supervisor or the nurse directly… immediately gave feedback on the spot, without me asking for it." (S7-FGD3)*
		"Is it because they are used to it, so for example, I will do this after this, and after that I will get feedback, so that in the end they will think that I don't need to ask, because surely later the lecturer will automatically give me feedback, thought like that. So, they themselves don't want to ask, because they are used to receiving passively." (CT5In5)
•	Blaming culture	*"From childhood it was used to being blamed, then getting the consequences of that mistake, so most of us don't dare to ask that way." (S1-FGD5)*
Time context		
• Scheduled scientific sessions		*"Moments such as scientific moments and the doctor is willing; it is indeed a place where we can discuss everything." (M5-FGD1)*
• Informal sessions		*"Especially when I was on guard duty (with the resident) … In the informal session, I got more experience and feedbacks" (M6-FGD1)*

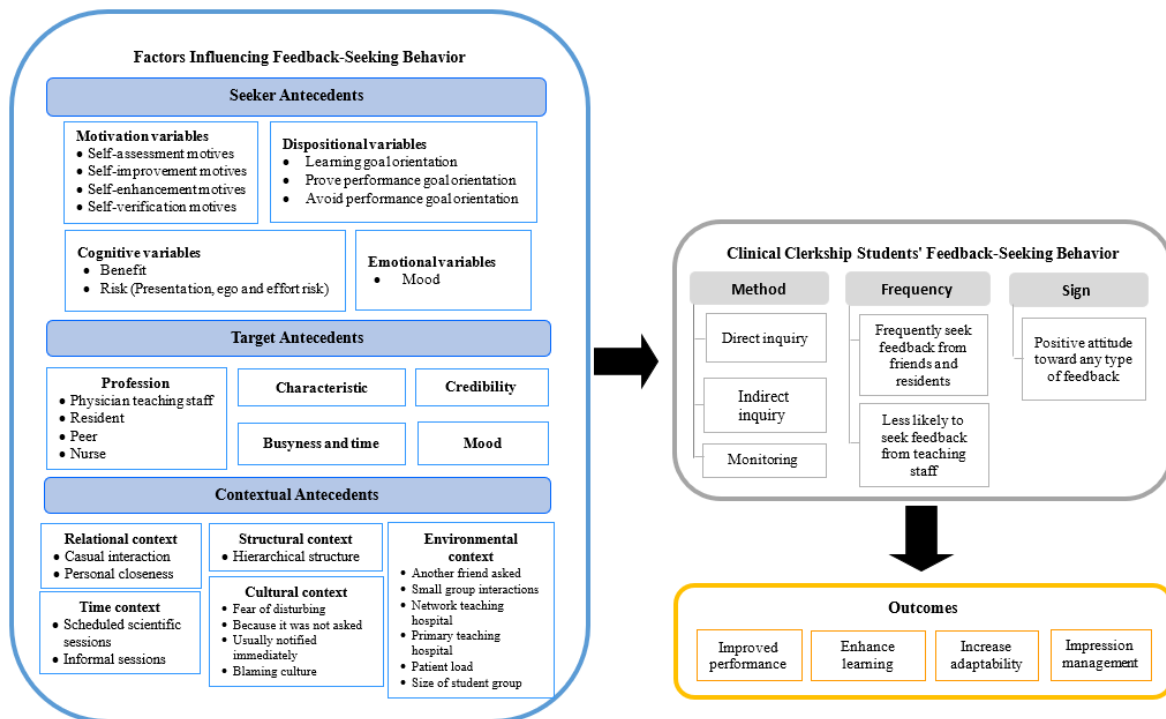The relationship between these themes can be seen in Figure 2.

Figure 2. Relationship between themes and subthemes

This study found that medical students' FSB during clinical clerkships is influenced by a range of antecedents. Seeker antecedents, such as motivation, goal orientation, perceived benefits and risks, and emotional states (e.g., mood), play a key role in shaping how students seek feedback. Target antecedents—including the profession, credibility, and availability of feedback sources such as physicians, residents, peers, or nurses—also affect students' decisions, especially in terms of whom they approach and how frequently. In addition, contextual factors, such as the nature of student–teacher relationships, hierarchical structures, cultural norms, and environmental conditions in clinical settings, contribute to the choice of feedback-seeking methods (direct inquiry, indirect inquiry, or monitoring). These influencing factors ultimately affect how often students seek feedback, from whom, and how they respond to it. In this study, students were found to seek feedback more frequently from peers and residents, while teaching staff was approached more rarely. Despite these differences, students generally demonstrated a positive attitude toward any feedback received. These behaviors were linked to several outcomes, including performance improvement, learning, adaptation, and impression management.

DISCUSSION

This study provides valuable insights into the factors influencing FSB among clinical clerkship students in high-power-distance cultures. The findings align with previous research, highlighting the complex interplay of individual, interpersonal, and contextual factors that shape students' willingness to seek feedback. Based on the results of the thematic analysis, the researcher categorized the themes and subthemes using the FSB framework developed for workplace settings, which includes antecedents, FSB, and outcomes (7,11,13). As shown in Figure 2, the factors influencing FSB among clinical clerkship students can be grouped into seeker antecedents, target antecedents, and contextual antecedents. The term "antecedent" refers to factors that precede and potentially influence the occurrence of FSB (7). These results correspond with the antecedents identified in workers FSB

models, which include the characteristics of the feedback seeker, characteristics of the feedback provider, and contextual factors (13).

There are notable differences between the antecedents of FSB in workers and those in clinical clerkship students. These differences are particularly evident in the target antecedents and contextual antecedents. In the FSB model for workers, feedback-seeking targets are limited to supervisors and coworkers. In contrast, this study reveals that clinical clerkship students seek feedback not only from faculty physicians but also from residents, other healthcare professionals, and peers. Additionally, while the FSB model for workers primarily considers the private or public nature of the feedback context, feedback-seeking in clinical learning environments is influenced by more diverse environmental factors. These include whether the clinical setting is a primary or affiliated teaching hospital, the number of students in a group, patient volume, and temporal factors such as scheduled academic sessions versus informal clinical encounters. These findings provide valuable insights into the unique characteristics of FSB among clinical medical students and help distinguish it from FSB in the workers.

This study found that clinical clerkship students in Indonesia rarely seek feedback from their supervisors. Instead, they more often seek feedback from peers or residents. Students feel more comfortable approaching residents than teaching staff because residents are closer in the professional hierarchy and are considered more empathetic, given that they are also in a learning phase. The demanding schedules of clinical teaching staff and limited availability often lead students to interact more frequently with residents and peers than with faculty members. These findings align with those of Suhoyo et al. (37), who reported that clinical students in Indonesia more often receive feedback from residents than from faculty physicians. Residents are more actively involved in students' day-to-day clinical activities and can provide timely, practical feedback. Their feedback is often perceived as more relevant and actionable, as it is based on direct observation (21,37). Moreover, the hierarchical structure of medical education and Indonesia's high-power-distance index shape the dynamics between clinical students and faculty physicians. The superior status of faculty often creates a sense of distance, making students hesitant to approach them for feedback (37–39).

The findings of this study indicate that students avoid seeking feedback due to fears of being unable to answer questions, being perceived as asking unnecessary questions, being scolded or blamed, or receiving responses that do not meet their expectations.The fear of receiving negative comments can hurt their self-esteem and ego (22,38). In addition, cultural influences within the Indonesian education system—where learners typically respond only when questioned by instructors—position students as passive recipients. As a result, they are unaccustomed to initiating questions and often feel confused or fearful of making mistakes when communicating with faculty members (22,24,26). A study by Sari et al. (40) on feedback communication in clinical education in Indonesia further supports this observation. It found that the feedback process reinforces a hierarchical relationship in which students are positioned below teachers. Students are accustomed to asking for permission before speaking to demonstrate politeness and often assume that they are inherently at fault. This perception creates psychological barriers that hinder open and effective feedback communication (40).

The results of this study also reveal that students are hesitant to seek feedback due to a fear of disturbing busy teaching staff, feeling unwelcome to ask questions, and being accustomed to receiving correction only when a mistake is pointed out. Students perceive that clinical teachers are too occupied with patient care and may consider unsolicited feedback requests as disruptive or disrespectful. Consequently, students tend to wait passively, assuming that if no feedback is given, their performance is satisfactory. From the students' perspective, scheduled scientific sessions—such as bedside teaching, case presentations, and handover (guard) reports—are the most appropriate opportunities to request feedback. During these sessions, teaching staff are perceived to be more available and open to discussion. Students feel more comfortable initiating feedback conversations at

these times, viewing them as rare chances to engage with otherwise busy faculty. Interestingly, while students see these scheduled sessions as opportunities, teaching staff may interpret student engagement during such times as mere formality, since discussions are expected parts of the session. Nevertheless, informal clinical moments—such as during outpatient duty or in the operating room—may also offer valuable feedback opportunities. These settings are typically more relaxed and involve smaller groups, reducing the perceived interpersonal risk of seeking feedback. This finding is consistent with a study by Felaza et al. (41), which showed that clinical students feel more comfortable seeking feedback in group settings. It is further supported by Suhoyo et al. (21), whose research on collectivist cultures revealed that faculty physicians tend to provide feedback in groups, while individual feedback is more commonly offered by residents.

Previous research on FSB (4,7,9,10), has indicated that students primarily seek feedback through inquiry and monitoring. However, it does not elaborate on the fact that inquiry can take both direct and indirect methods. This study adds to the existing knowledge by showing that medical students also employ indirect inquiry when seeking feedback in clinical settings—for example, by steering conversations toward topics on which they wish to receive feedback. In such cases, students initiate discussions with faculty on specific subjects without explicitly requesting feedback. Clinical clerkship students also use monitoring strategies by observing peers' mistakes and mentally noting the information to apply it to themselves. In addition, students monitor by accompanying teachers during procedures outside their scope of competence, using the opportunity to learn through observation. Indirect inquiry and monitoring strategies are often used to avoid the perceived risks associated with directly requesting feedback (35,38).

This study also provides a more detailed perspective on students' feedback-seeking motives by identifying four distinct types: self-assessment (seeking accurate self-knowledge), self-improvement (aimed at developing skills and performance), self-enhancement (seeking positive self-views), and self-verification (seeking confirmation of one's self-concept) (9). While earlier studies have grouped motives into learning, image, and ego categories (9,35,36), ego-related motives remain underexplored in undergraduate education, as noted by Leenknecht and Carless (35). Therefore, this study adopts the classification from Crommelinck and Anseel (9), which offers a more specific framework for understanding the individual and situational factors that influence FSB.

Another key finding from this study is that the clinical learning environment also influences the FSB of medical students. In tertiary teaching hospitals, where patients tend to present with more complex conditions, students are less likely to seek feedback, as they often perceive these cases to be beyond the scope of general practitioner competencies. In contrast, students placed in affiliated hospitals or primary care settings tend to be more active in seeking feedback because the cases encountered are more aligned with the competencies they are expected to develop. The volume of patients also plays a role; in particularly busy clinical settings, students are more likely to observe rather than actively seek feedback, as faculty members are primarily focused on patient care. Moreover, the number of students in each clinical rotation group affects the extent to which faculty can observe student performance—smaller groups allow for more individualized attention and timely, relevant feedback.

In this study, students generally held a positive interpretation of feedback-seeking, regardless of whether the feedback was positive or negative, viewing it as a normal part of the learning process. They were not particularly troubled by negative feedback as long as it included guidance on what should be done differently. Acknowledging their limited knowledge, students perceived corrective feedback from faculty as valuable input for their development. However, responses to feedback are also shaped by goal orientation—students with a learning goal orientation will react positively and optimistically, believing that self-ability can be improved by seeking feedback, compared to those with a performance goal orientation (42).

These findings have significant implications for medical education. To foster a culture of feedback-seeking, educational institutions should cultivate a supportive and inclusive learning environment that promotes open communication and collaboration. One effective approach is to implement regular, structured feedback sessions during clinical rotations, such as after case presentations or during bedside teaching (43). Setting scheduled feedback times can help reduce students' hesitation in high-power-distance cultures, where unsolicited feedback-seeking may feel uncomfortable or disrespectful. Optimizing the role of feedback providers beyond faculty members is a potential strategy to address the hierarchical structure and high-power distance commonly found in medical education. Providing training for all potential feedback sources within clinical settings—not only faculty physicians but also residents and other healthcare professionals—on both giving and seeking feedback can enhance their credibility as feedback providers and help create a more supportive feedback culture. This includes methods for providing feedback in ways that respect hierarchy but also empower students to engage in two-way communication. Strategies such as using indirect or group-based feedback discussions may help students feel more comfortable (21). Institutions can also encourage peer observation and promote the use of 360-degree feedback among students to normalize both seeking and providing feedback as part of maintaining harmony and preventing conflict (26). Peer-to-peer feedback should aim to support individual growth by exploring challenges and collaboratively discussing strategies for improvement. Embedding simulation activities or role-playing exercises that mimic feedback-seeking interactions in clinical settings can give students low-risk opportunities to practice these skills. This type of training can improve students' confidence and competence in seeking feedback, making them more comfortable engaging in these behaviors despite hierarchical concerns (44).

It is important to note that this study has limitations. Potential biases can arise in virtual FGDs and interviews due to factors such as unstable internet connections or background noise, which can disrupt the flow of conversations. Moreover, virtual settings may limit the ability of participants and moderators to perceive nonverbal cues—such as body language or facial expressions—that are crucial for interpreting emotions or hesitation, particularly when discussing sensitive topics. To mitigate this limitation, participants should be encouraged to keep their cameras on and actively contribute to the discussion. Another limitation is the relatively small and homogeneous sample of faculty members, which may constrain the generalizability of the findings. Furthermore, although rigorous qualitative analysis methods were applied, reliance on transcribed interview data introduces the possibility of interpretative bias.

Future research should focus on creating and validating tools to measure FSB and its outcomes across culturally diverse contexts. Such tools could assess students' perceptions of hierarchy and their comfort with seeking feedback, providing institutions with actionable indicators for improvement. Comparative studies examining FSB among medical students in high-power-distance cultures, such as Indonesia, and those in low-power-distance cultures could provide valuable insights into the role of cultural factors. These findings could help tailor feedback practices that are both culturally sensitive and conducive to effective learning. Future studies should also consider employing hybrid and mixed-methods approaches to explore FSB in larger, more diverse samples of medical students across various institutions. Additionally, longitudinal studies could examine the impact of interventions aimed at promoting FSB on students' learning outcomes and professional development.

CONCLUSION

In conclusion, this study contributes to a better understanding of FSB among medical students in Indonesia by illuminating the intricate interplay of personal, relational, and contextual factors within a high-power-distance cultural setting. To foster a culture of open and effective feedback in clinical

education, institutions should prioritize faculty development initiatives that emphasize relational teaching approaches and promote psychologically safe learning environments. Furthermore, encouraging peer observation and integrating 360-degree feedback practices among learners may help normalize feedback-seeking and contribute to a more sustainable feedback culture. Overall, the findings offer practical insights for the development of targeted interventions aimed at strengthening feedback practices in clinical education.

ACKNOWLEDGEMENTS

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