

# Feedback in the nonshifting context of the midwifery clinical education in Indonesia: A mixed methods study

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## ABSTRACT

**Background:** Clinical education in some countries applies a hospital-based learning approach where each student rotates to one division to another division (call of shifting). However, for clinical midwifery education in Indonesia each student remains in a community midwifery clinic (call of nonshifting). Because of the differences in the shifting system used, the question of “How is feedback in the nonshifting context of the clinical midwifery education being given?” needs to be explored.

**Materials and Methods:** This was a mixed methods study and was carried out in a School of Midwifery in Indonesia during 2014 and 2015. We explored the supervisors’ and students’ perception on the feedback delivery. Students’ perceptions were collected through focus group discussions whereas supervisors’ perceptions were recorded through interviews. The quality of feedback was observed using a checklist. Qualitative data were analyzed using *Atlas Ti* and quantitative data were analyzed using a descriptive statistic method.

**Results:** From the qualitative data, students and supervisors perceived their feedback as “more intensive.” They reported authenticity in the monitoring and feedback from the day-to-day delivery of patient care with their supervisors. Students and supervisors also described their feedback as “more integrated.” The feedback process stimulated students to value history taking, physical examination, and midwifery care. On the other hand, quantitative data from observations presented that “intensive and integrated feedback” were not supported by the quality of the feedback based on literature of the theory of facilitating learning (the mean was 4.67 on a scale of 0–9).

**Conclusions:** The nonshifting clinical midwifery education can be a better alternative for facilitating the process of providing integrated and intensive feedback. To improve the quality of the feedback, training on providing feedback in a nonshifting context is fundamental in Indonesia.

**Key words:** Community-based education, constructive feedback, midwifery clinical education, nonshifting context

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Submitted: 28-Aug-15; Accepted: 07-Apr-16

## INTRODUCTION

Feedback is one of the ways to improve students’ achievement during their learning process.<sup>[1]</sup> Feedback provides students the information concerning their current achievement, what has not been achieved, and what needs to be achieved.<sup>[2]</sup> Therefore, feedback is an important indicator of the success of the learning process,

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**How to cite:** Nugraheny E, Claramita M, Rahayu GR, Kumara A. Feedback in the nonshifting context of the midwifery clinical education in Indonesia: A mixed methods study. *Iranian J Nursing Midwifery Res* 2016;21:628-34.

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	DOI: 10.4103/1735-9066.197671

and is often referred to the lifeblood of learning.<sup>[3]</sup> Because of the importance of constructive feedback, the International Confederation of Midwifery (ICM) has recommended constructive feedback as one of the strategies for formative assessment.<sup>[4-6]</sup>

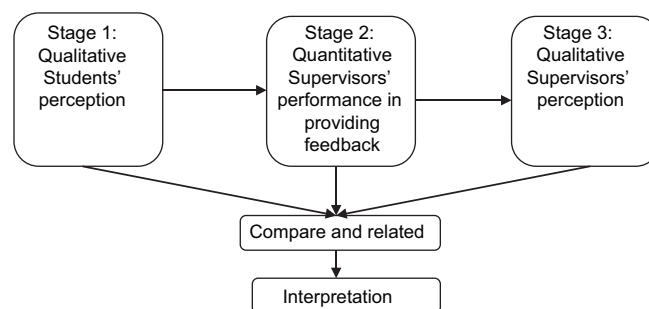
Studies have shown that even though clinical supervisors play important roles in supervising their students, their competence in providing constructive feedback is inadequate.<sup>[7-9]</sup> On the other hand, students need intensive feedback from their supervisors to boost their confidence.<sup>[6,8,10]</sup> Feedback should be based on continuous processes, including observing, assessing, and providing feedback.<sup>[6]</sup> Previous studies have shown that the quality of continuous interaction between students and their supervisor varies in terms of the interval, frequency, and duration of consultation.<sup>[11,12]</sup> The goal of learning can be achieved if students are guided by a supervisor continuously over a period of time.<sup>[6]</sup> Through continuous feedback, it is expected that the quality of students' learning process can become better.

Previous studies have discussed feedback in a shifting context (hospital-based), for example how feedback is given among obstetric gynecology residents during clinical night shifting, among residents in accident and emergency department, and in the ambulatory care setting.<sup>[9,13,14]</sup> Midwifery education in Indonesia has a specific nonshifting clinical context. During the nonshifting clinical education, each student rotates in a community midwifery clinic and is supervised by two senior midwives for a six week clinical rotation. Midwifery education in the United Kingdom also uses a similar community-based midwifery clinic.<sup>[15]</sup> However, we found no literature regarding giving feedback in the nonshifting midwifery clinical educational context.

In the nonshifting midwifery clinical education, where students and supervisors meet regularly on a daily basis, it is expected that the feedback can be given intensively and continuously. Therefore, we aim to explore the characteristics of the feedback given in the community-based nonshifting context because of the limited evidence and the differences between the nonshifting and the shifting context. The objective of this research is to investigate 1) what is the clinical supervisors' and students' perception regarding feedback delivery in the nonshifting midwifery clinical education and 2) how is the current quality of feedback in the nonshifting context in Indonesia?

## MATERIALS AND METHODS

This was a mixed methods research with a multi-phase design using a sequential approach. Figure 1 illustrates the



**Figure 1:** The stage of the study

sequence of this study. The mixed methods design was used to validate qualitative findings with quantitative data.<sup>[16]</sup> This study was conducted at Ummi Khasanah School of Midwifery in Indonesia during the clinical learning period of 2014-2015. Qualitative data were collected by focus group discussions (FGDs) with students and in-depth interviews with clinical supervisors. The quantitative data were collected by observing and rating the quality of the supervisors' feedback. Data were reported using descriptive open coding and tables.

Forty out of 240 students were selected for FGDs using the following criteria: Second and third year students who had completed clinical rotation in a community-based midwifery clinic. We invited 15 midwives, whose community clinics were used for student rotation, during data collection and interviewed them personally. After the interview, we observed their skills in giving feedback using a nine-point checklist. During the observation period, each midwife gave feedback to 1-2 students. Table 1 depicts the characteristics of the midwives and students.

We developed guidelines for the FGDs and interviews. We constructed a nine-point checklist for observations based on recommendations from Hewson and Little.<sup>[17]</sup> Basically, the FGDs and interviews explored how the feedback was conducted. The FGDs included questions such as how do you think does the supervisor provide continuous feedback in the learning process and when does the supervisor provide feedback? The interviews included questions such as please explain what was your method to provide feedback and did you give feedback verbally, or in writing, or both? The checklist for observation consisted of nine technical indicators: 1) Observation based; 2) on time; 3) being nonjudgmental; 4) relating feedback to specific behaviors; 5) focused; 6) facilitate dialogs; 7) facilitate self-evaluation; 8) constructive; and 9) offering suggestions for improvement. To determine the validity of the research instrument, researchers used content validity with expert judgment and reliability analysis with Cronbach alpha value (0.6). An alpha value of 0.6–0.7 indicates acceptable reliability.<sup>[18]</sup>

**Table 1: The characteristics of respondents**

Category	f	%
The characteristics of students (n=40)		
Gender		
Female	40	100
Year level		
II	22	55
III	18	45
GPA		
<3.00	5	12.5
>3.00	35	87.5
The characteristics of supervisors (n=15)		
Education		
Diploma III	8	53.3
Diploma IV	5	33.4
Master degrees	2	13.3
Experience of being a supervisor		
<1 year	2	13.3
1-3 years	2	13.3
3-6 years	5	33.4
6-9 years	4	26.7
>9 years	2	13.3
Supervisor training		
Yes	12	80
No	3	20

We divided forty students into four groups for four FGD sessions. Each session lasted for 1.5 hours. The FGDs were audio recorded and additional field notes were made. One of the researchers (EN) visited each midwife for interviews. The interviews were audio recorded and additional field notes were prepared. The researchers (EN) observed all 15 midwives. Each observation lasted 30–60 min per student per patient, starting from the initial patient–student encounter until the final feedback session. The data collection lasted for three weeks. The collected data were then transcribed by the researcher assisted by three trained research assistants.

The qualitative data were analyzed using content analysis method with *Atlas Ti*.<sup>[19]</sup> To increase the trustworthiness of the qualitative data, we used conformability and internal validity. The conformability was used to document the procedures for checking and rechecking the data throughout the study. The conformability process with to give meaning the transcript that have been made by a research assistant with the open coding. The open coding process was conducted by two research assistants with experience in conducting qualitative research. The agreement of coders was obtained after two discussions to made continuity

categories. Each discussion with took about four hours. We also performed internal validity to ensure that the results were credible or reliable from the perspective of the participant. The process of internal validity with a member checking. The member checking process was performed with ten students and 12 supervisors separately.

### Ethical consideration

This study was approved by an institutional review board. Research ethics has earned the ethical consent according to the World Medical Association's Declaration of Helsinki–Ethical Principal for Medical Research Involving Human Subjects Issued by Universitas Gadjah Mada, Yogyakarta, Indonesia.

## RESULTS

### Feedback in the nonshifting context based on the perceptions of supervisors and students

From the qualitative data, there were 14 categories from FGDs and 36 categories from interviews. Fifty categories were grouped into two themes of providing feedback in the nonshifting context of the clinical midwifery education. We noted both specific and general findings in this study, as shown in Table 2.

In this study, the respondents perceived that a more “focused feedback” was not suitable for a nonshifting clinical midwifery education; instead the feedback should be more “integrated”. They perceived that “focused feedback” may lead the students to only comprehend some part of the procedure. On the other hand, “integrated feedback” may stimulate students to be more able and confident in managing other cases because feedback previously provided by supervisors can be applied more comprehensively.

Students and supervisors had the same perceptions about the benefits of the nonshifting learning process. In this kind of a learning setting, feedback may be given more intensively because discussion may be done at any time. Learning activities in the nonshifting context provided more opportunities for supervisors and students for engaging in a more intensive relationship. In addition, in the nonshifting context, feedback could be more sustainable because the students worked together with their supervisors in the same place for a period of six weeks. In the nonshifting context, feedback was given both individually and in a group. Individual feedback was given more intensively compared to group feedback. Individual feedback was given regularly and promptly on a daily basis immediately after the observation. Group feedback was given regularly once

**Table 2. The perception of supervisors and students regarding feedback in the nonshifting clinical midwifery education**

Theme	Category	Quotation	
		Supervisors	Students
Specifics findings of this study	Feedback is more intensive in the nonshifting context	<i>"Time for giving feedback was usually after completion of service, accessible every day around 9.00-11.00 PM depending on the circumstances. The allocation of time could be up to two hours." (Midwife P4:11)</i>	<i>"Every day I get feedback directly while providing care in to patients. In the leisure time, the supervisor discuss the feedback that has been given above." (Students P2: 5)</i>
	Feedback is more integrated in the nonshifting context	<i>"I usually give feedback comprehensively. I hope in the future, the students will improve in the performances. It is okay if there are plenty of feedbacks in the beginning as there are a lot of things they really should improve. I hope they always remember. If I don't let them know about the mistake, they will think everything is OK." (Midwife P1:8)</i>	<i>"The supervisors usually gave feedback comprehensively, about history taking, physical examination as well as providing midwifery care." (Students P4: 3)</i>
General findings of this study			
Appropriate feedback found in this study	The Feedback was observation-based	<i>"We were supervising based on direct observation." (Midwife P5:9)</i>	<i>"When I was conducting practice at times of delivery assistance and I did it incorrectly, the supervisor told me directly because she was always behind me." (Student P3:13)</i>
	The feedback was timely	<i>"I evaluated their work right away. They were not treated as a student but as a professional just like our teammate. So I assisted them using comprehensive supervision and direct corrective feedback." (Midwifery P5:9)</i>	<i>"The feedback is given right away in the direct supervision." (Student P3:26)</i>
Inappropriate feedback found in this study	The feedback was not support self-evaluation	<i>"I let them know about their mistakes from my perception. But, I did not ask them to evaluate by themselves first, prior to the feedback session." (Midwife P10:25)</i>	<i>"The Midwife directly told me what I did wrong, what my faults and my weaknesses were." (Student P14:8)</i>
	The feedback was not facilitate dialogs	<i>"I rarely discussed with them. I focused more on improving their skills because I am a clinical midwife." (Midwife P4:3)</i>	<i>"I did not dare to argue the supervisors because I did not want to be perceived as stubborn." (Student P18:65).</i>
	The feedback was not constructive	<i>"Compliments were never given in front of other students. Besides, the rewards from me is not always in the form of compliments but can be in the form of score." (Midwife P14: 21)</i>	<i>"Usually they (midwife) directly informed about our mistakes." (Students P10:30)</i>
	The feedback was not support following up plans	<i>"I just make following up plans if there are students who find difficulties in learning." (Midwife P14:24)</i>	<i>"There were following up plans but they rarely did." (Student P33:15)</i>
	The feedback was not written	<i>"I think students are more able to recall with a reprimand (oral) than writing." (Midwife P5:1)</i>	<i>"There is no written feedback. The oral feedback is more preferable because it has intonation." (Student P1:21)</i>

or twice a week, and was given to several students from one institution as well as from several institutions.

According to the students, the supervisors rarely facilitated dialog [Table 2]. The supervisors tended to dominate the talk and carried out a one-way communication. The students tended to be passive because they only listened to the shared feedback. Students had the perception that the supervisors were more senior with more clinical experiences; therefore, they were sure what the supervisors did was correct, and they did not have the courage to question them. The students were afraid that they might be regarded as stubborn students if they argued, and were worried that their supervisors would give them a bad score and would not want to assist them. The respondents' perceptions indicated that the feedback was more "clinical skills oriented." The students and the supervisors shared the same perceptions that the given feedback had not discussed the positive aspects shown by

the students, but instead focused only on the weaknesses of the students. However, this kind of feedback was not well conducted because the supervisors thought that the reward given to the students could be in the form of a good score. Therefore, the supervisors were still doubtful regarding the use of formative and summative assessment.

The feedback in midwifery education in Indonesia mostly is given verbally and not in a written format. According to the supervisors' perceptions, the feedback was conducted verbally because the written instrument for giving appropriate feedback was not available. Supervisors thought that the feedback was shared but there was no evidence because it was not documented. Therefore, it is a necessity in the view of both students and supervisors to design an instrument for giving written feedback as a part of a clinical learning guidance book. The respondents proposed that the feedback instrument could be used in a



controlling and connecting context between students and their supervisors so that each party could monitor and evaluate the learning process.

### Observation results

From the quantitative data, based on the observation of this study done by the first author, the following was the highest rated feedback technique; the feedback was given on time based on observation. On the other hand, the lowest rated feedback technique was constructive feedback which had not facilitated an action plan. Figure 2 depicts observation results. The performance of supervisors in giving feedback was moderate because the mean score was 4.67 on a scale of 0 to 9 (SD 1.9). The highest score was 8 and the lowest score was 2 based on the nine assessment indicators proposed by Hewson and Little.<sup>[17]</sup>

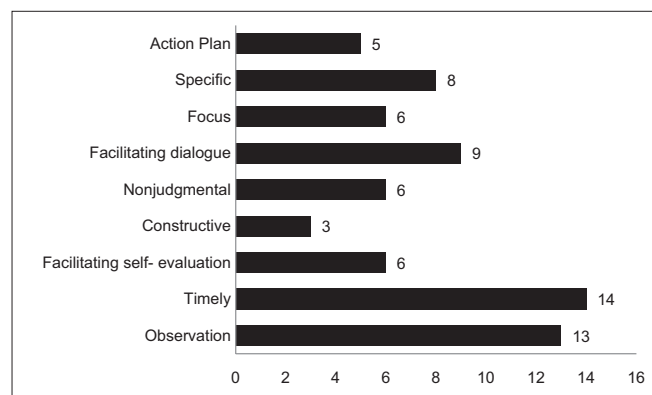
### DISCUSSION

The qualitative data shows that according to the students' and teachers' perception, the feedback was more "intensive" because it was shared frequently; on the other hand, the feedback was more "integrated" because they thought that they may be able to stimulate students' comprehension on the midwifery care. However, the results of the observation checklist using the Adapted Recommended Technique of Hewson and Little<sup>[17]</sup> shows that the content of the feedback did not meet the expectations of the guidelines. Therefore, there are contradictory results concerning the perceptions of students, teachers, and observers.

Other results of this study indicated that appropriate feedback was difficult to share, and this problem was quite common, as reported in previous studies.<sup>[5,9,14,20]</sup> In our study, the supervisors rarely provided constructive feedback and did not facilitate the students to perform self-evaluation and prepare action plans. If any positive feedback was shared, it was often emphasized in the form

of academic scores. This pattern was observed because the supervisors focused specifically on mentoring clinical skills and not on the learning process in general. The tendency of giving primarily negative feedback makes the students to experience a hesitation toward learning. The supervisors might not understand their role as facilitator to provide constructive feedback neither do they understand the concept of summative and formative assessments.<sup>[6,8,9]</sup> These findings demonstrate how urgent is the feedback problem of clinical supervision in the nonshifting clinical midwifery context. With a more constructive feedback, we expect that students could be more motivated to perform better.<sup>[20,21]</sup> However, in a nonshifting clinical midwifery education context, we expect that providing feedback should be of a higher quality because it provides more opportunities for building intensive relationships between students and supervisors.

However, there were contradictory results where some students perceived that the supervisors did not facilitate dialog. Meanwhile, observation showed that the supervisors did facilitate dialogs. Possibly, this happened because the students were actually not prepared to conduct any discussion with their supervisors, and hence, they tended to be more passive. Furthermore, perception of an absence of dialog possibly occurred because students assumed that the supervisors were exhibiting unfriendly expressions based on the students' interpretations indicated in the results. In this context of the study, in the culture of Southeast Asia, nonverbal communication is essential for students because it may cause comfortable or uncomfortable feelings, which potentially influences the general learning environment, including the opportunity for a dialog between the teachers and students.<sup>[22]</sup> These possibilities support social theories regarding the presence of hierarchical gaps, such as seniority and doctor-patient relationships, which also contributed to the absence of dialogs in this culture. A previous research in the area of doctor-patient communication in Southeast Asia found that patients were passive in communicating with their doctors because of the social hierarchical gap.<sup>[23]</sup> In similar settings, the social hierarchical gap in another context was found in a nurse-patient communication study.<sup>[24]</sup> Both these studies support the research by Clifford Geertz (1926-2006), an American anthropologist who discovered the existence of deeply embedded social hierarchy gaps in the Indonesian society.<sup>[25]</sup> The results of this study also validate social hierarchical gaps between the students and supervisors in the context of clinical midwifery education in Indonesia. In this study, we found two of the three keywords, "feeling afraid" and "feeling hesitant," that reflect a social hierarchical gap found by Geertz<sup>[25]</sup> toward someone who is perceived as higher hierarchy such as parents, teachers, and health professionals. For example, students will respect



**Figure 2:** Providing feedback in nonshifting context based on recommended technique ( $n = 15$ )

an elder as the higher hierarchy, and automatically they will be a passive listener and will hesitate to argue by remaining silent. Therefore, one-way communication is a norm in this culture.<sup>[26]</sup> This pattern of less dialog during communication was also found in the learning and working environment; where seniority was a culture, dialogs would likely not happen. It is a fact that dialogs are necessary in order to discuss students' perspectives, and such a social structure neglects this sharing in the learning process.<sup>[27]</sup> Although a nonshifting context provides more opportunities for students and supervisors to interact, this interaction and the required dialog was difficult to facilitate because of the presence of a social hierarchical culture gap between students and teachers.

The feedback in the midwifery education in the nonshifting context is unique compared to the shifting context (i.e., hospital-based education). In the area of feedback delivery in clinical education, previous studies recommended "focused feedback," that is to comment only on certain specific behavior and not to refer to a more general behavior.<sup>[17,19,28]</sup> Whereas, in this study, the respondents perceived that the "focused feedback" approach was not suitable for nonshifting clinical midwifery education; instead, the feedback should be a more "integrated" one. The "integrated feedback" in a nonshifting context implies that the supervisors provide feedback based on the observation of the students when, or immediately after, they do all of the following activities: Taking history, conducting physical examination, and providing midwifery care. The "integrated feedback" context also implies that the students were expected to understand the patients holistically and more deeply because they follow patients on an ongoing basis; for example, when handling patients in labor, they can follow-up with the patient up to postpartum and also provide baby care. Learning in the nonshifting context also provided an overview of a more holistic role of midwives in the society; students are also involved to help midwives in other contexts such as home care. Based on the perceptions of the students, if the feedback was more comprehensive, they may understand the overall expectations of the supervisor and will be able to perform better in the future. The "integrated feedback" in a nonshifting clinical midwifery education was congruent with the use of the integrative learning model that had a goal of linking the knowledge and skills from the students' prior experiences so they are able to apply what they already learnt in various clinical settings.<sup>[29]</sup>

Furthermore, feedback in the nonshifting context could be given more intensively because interaction between clinical supervisors and students may be done at any time, starting from the initial students–patients encounter until the

final feedback session. At the time of the students–patients encounter, feedback was given using a code that was previously agreed by both parties. The discussion between the students and supervisors could then be carried out whenever there are no patients or during their leisure time. In their free time, the supervisors may provide information about all the patients who were visited on that day. During such dialogs, the supervisors may explain about the correct techniques in providing quality care. Therefore, more intensive and integrated feedback are the two specific findings of this study, which is rather different than that of the previous studies done in the context of delivering constructive feedback in clinical education.<sup>[17,20,28]</sup>

The feedback concerning clinical midwifery education in this study was found to be given verbally. Written feedback was not provided. According to the respondents' perception, because no feedback instrument was distributed, all feedback was given verbally. Both, the students and the supervisors, felt that if the students could listen to the intonation during the delivery of the feedback, they could focus on the critical points. Although students and supervisors were satisfied in receiving and providing verbal feedback, they still perceived that a written feedback was more important. Written feedback could help the students to remember the oral feedback that was shared, and as a medium of communication between the students, could assist clinical supervisors and academic supervisors in evaluating the learning process in a clinical setting. Previous research found that the written feedback guidance was needed as one of the indicators that support the success of providing feedback and stimulate the students to improve their performance.<sup>[30,31]</sup>

### Study limitation and recommendation

This study was conducted only in one institution and one region. First, further studies are required to determine whether results similar to ours can be obtained in other contexts whose midwifery clinical learning context differs from that of Indonesia. Second, further research is required for appropriate training and appropriate module on providing a more constructive feedback in the nonshifting midwifery clinical education context.

### CONCLUSION

The nonshifting midwifery clinical education context is expected to be able to minimize the problems concerning feedback that are commonly found in the shifting context. In this nonshifting context, feedback could be given in a more integrated and intensive manner. Feedback is delivered in a more holistic manner considering the patient-centered care principles. Furthermore, the feedback can be shared at

any time because the students and the supervisors remain in a community-based educational context for a learning period of six weeks. The results of this study may be used by any midwifery educational institution in designing a more appropriate feedback training in order to improve the quality and quantity of feedback shared in the nonshifting context of midwifery education.

### Acknowledgment

We thank the students and the supervisors of the Ummi Khasanah Midwifery School, Yogyakarta, Indonesia, for their participation in this study. We also thank Rossi Sanusi, PhD and Erik Christopher for editing the final version of this manuscript.

### Financial support and sponsorship

Nil.

### Conflicts of interest

There are no conflicts of interest.

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