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JUDUL : **A qualitative study on patients' selection in the scarcity of resources in the COVID-19 pandemic in a communal culture**

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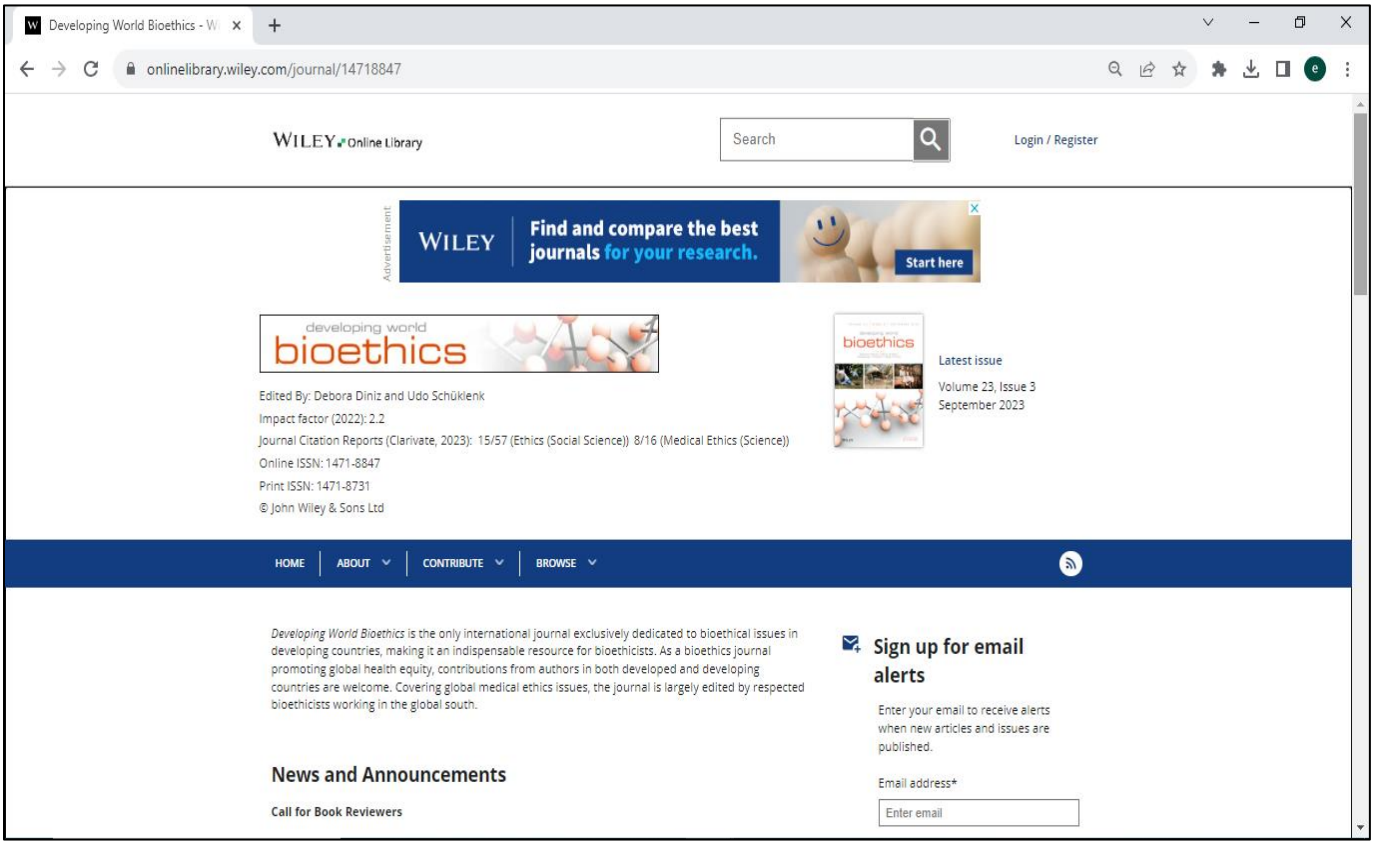

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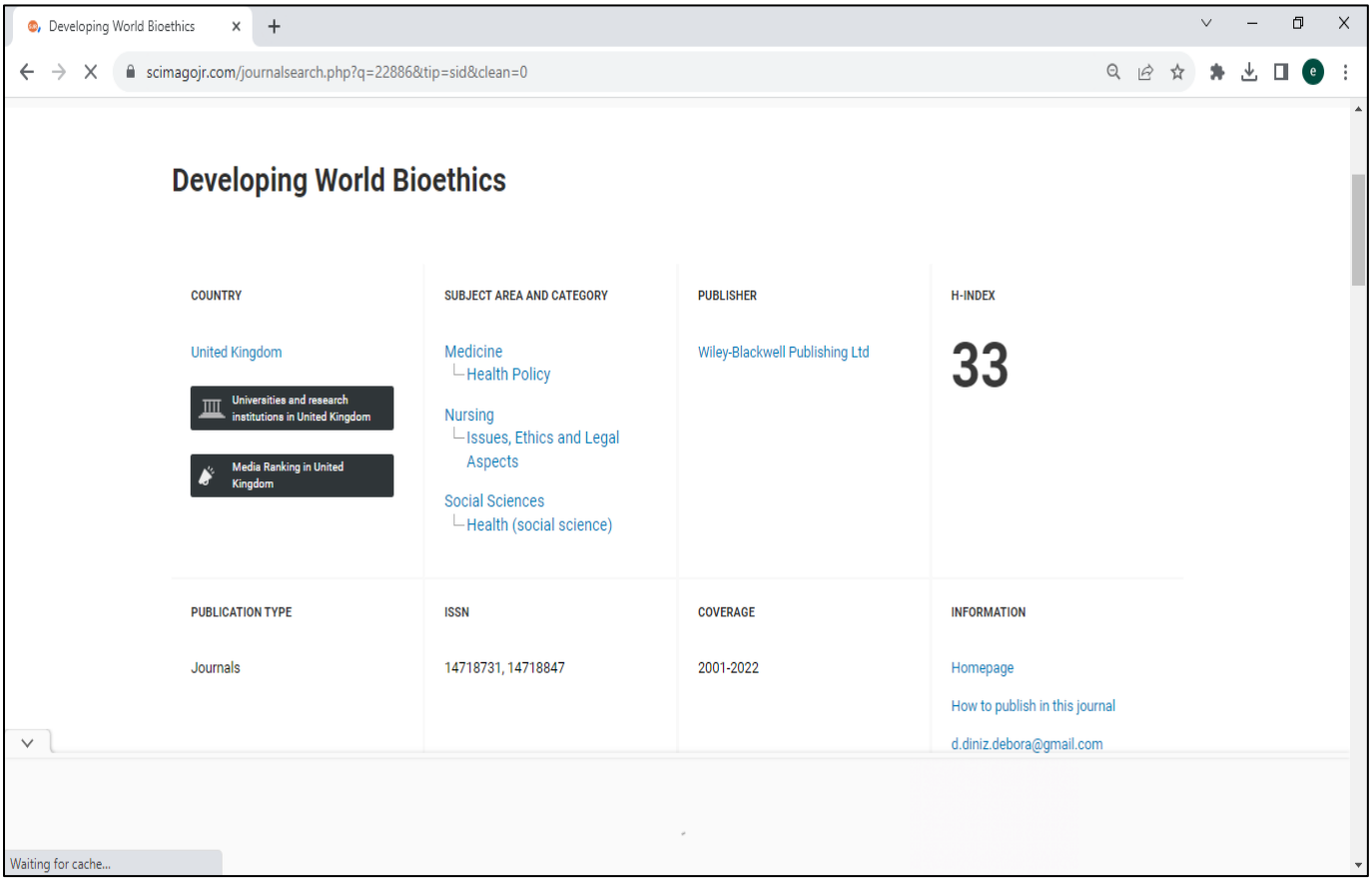

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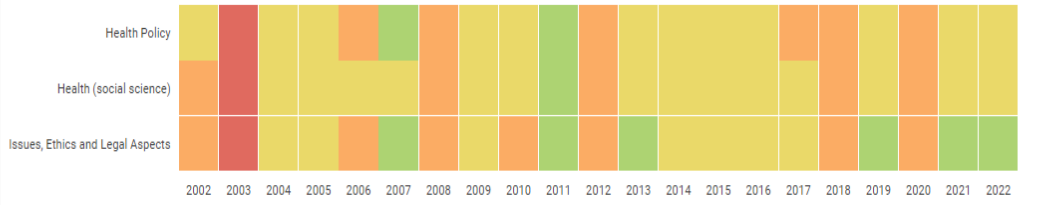

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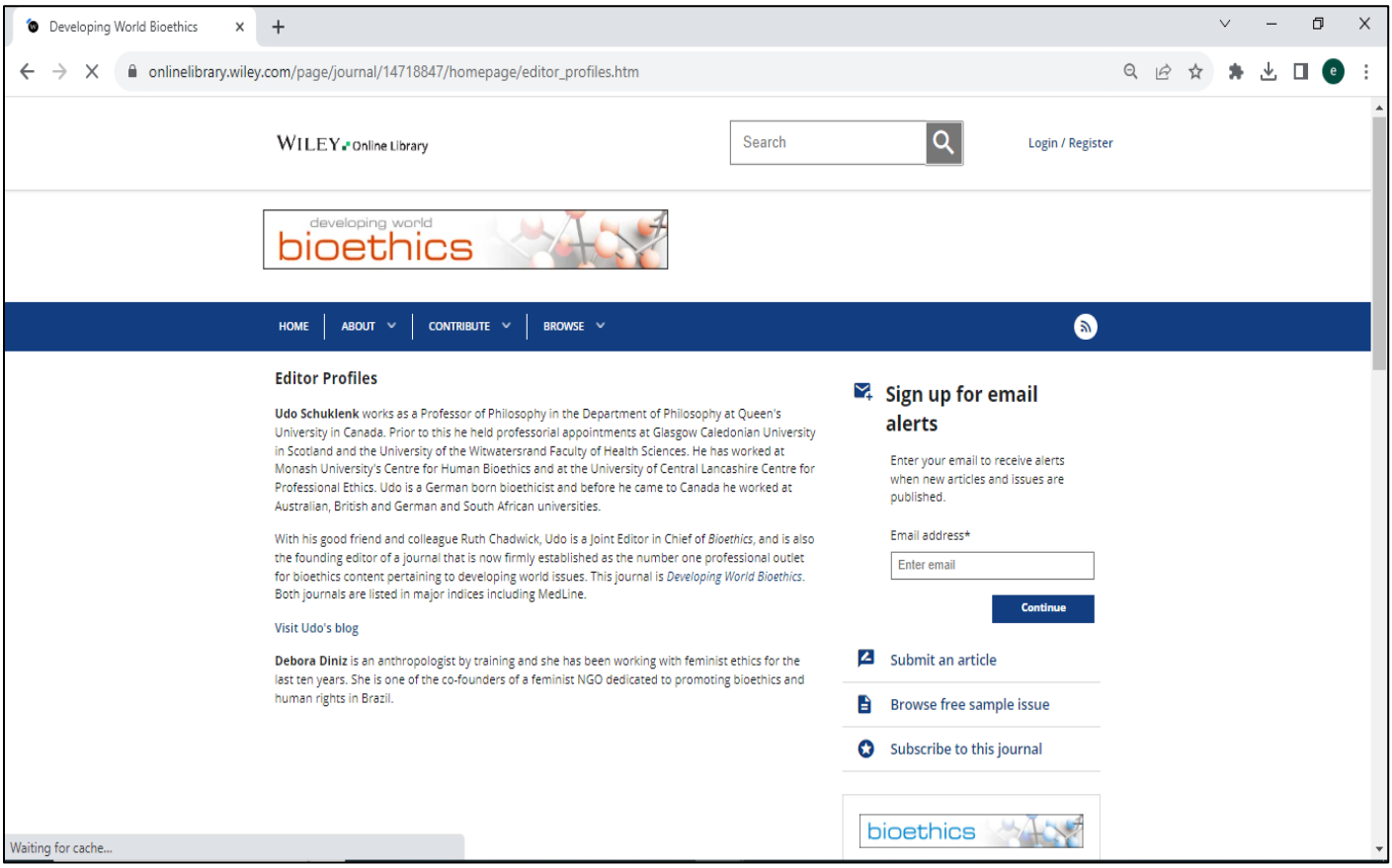

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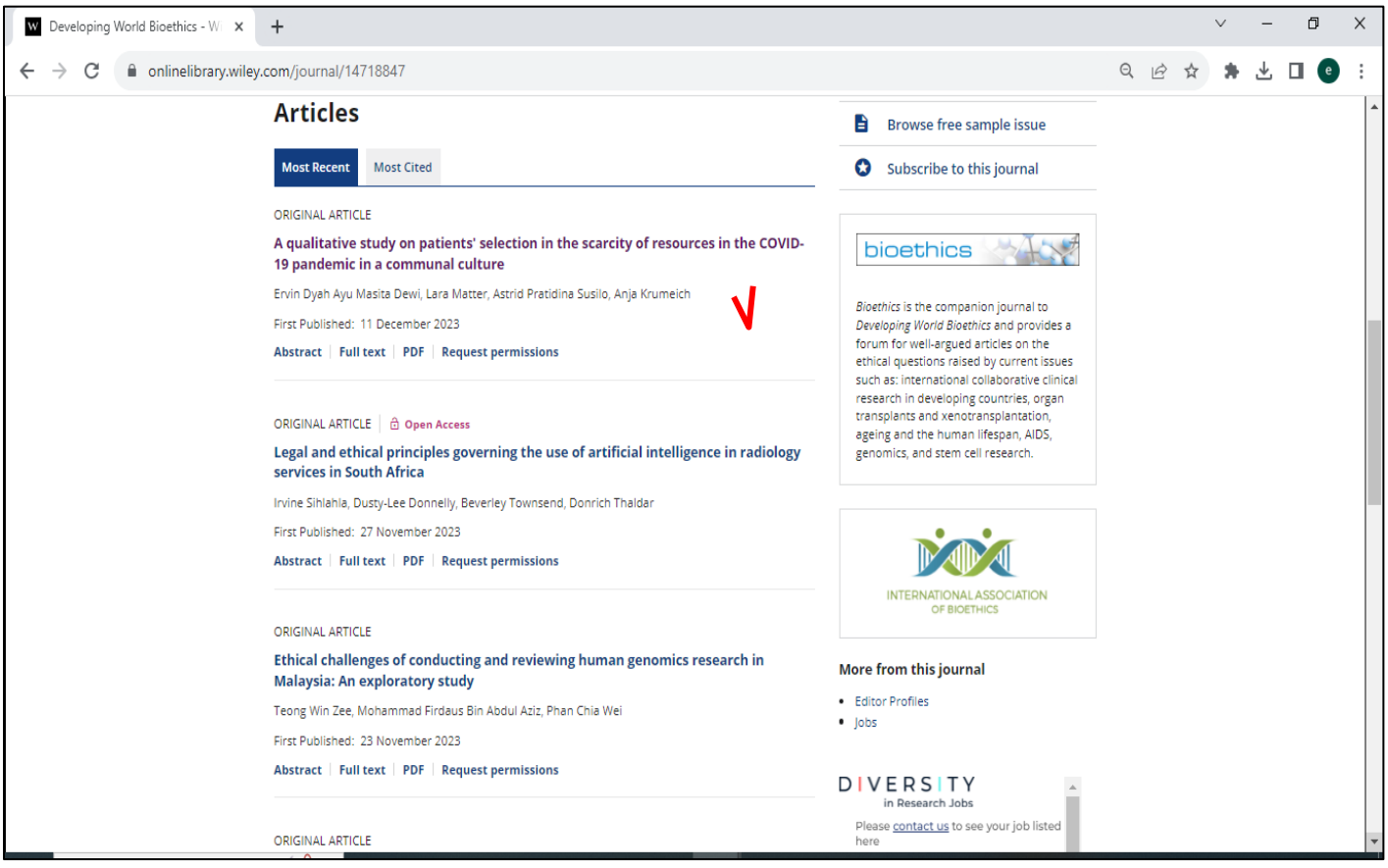

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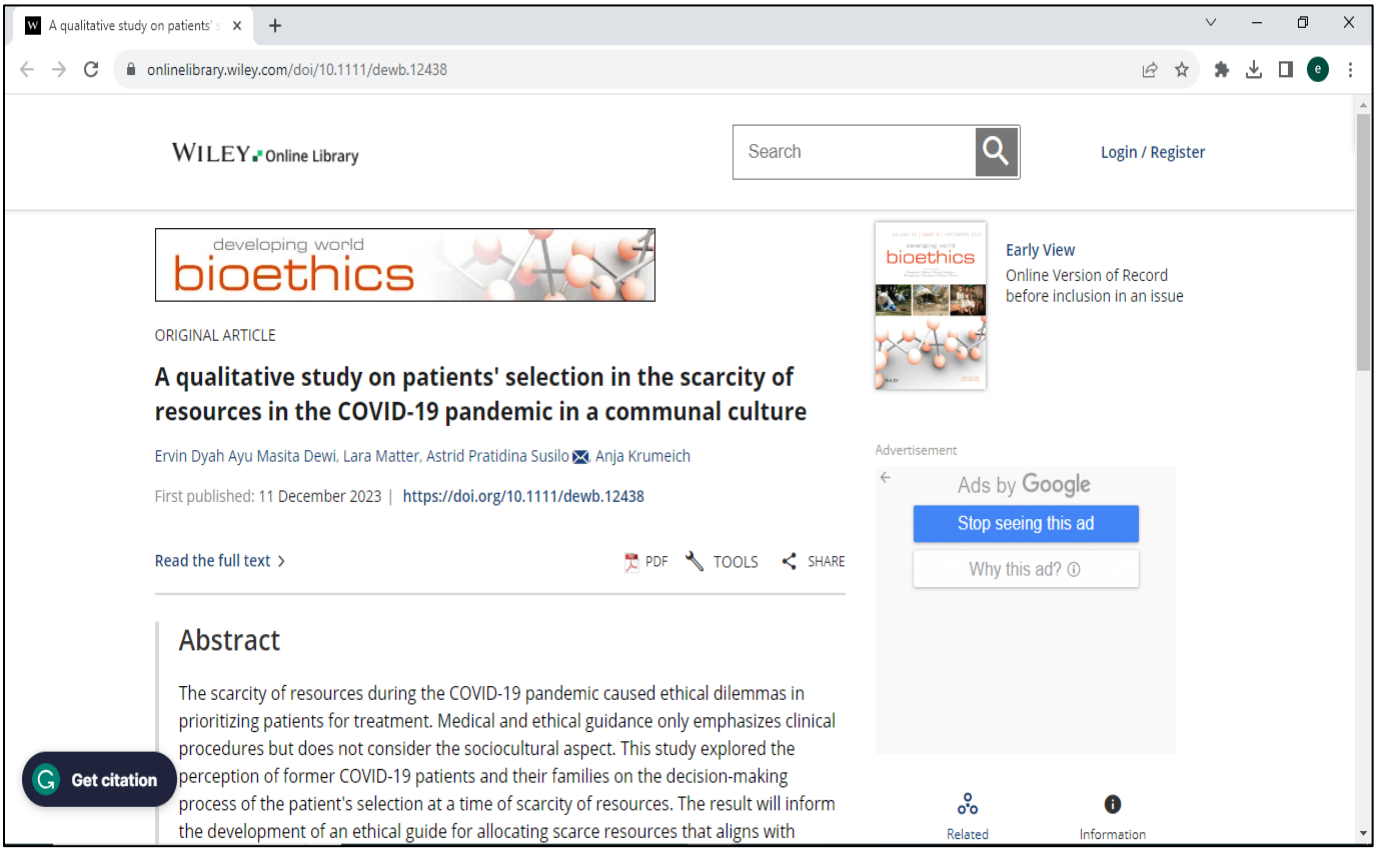

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A qualitative study on patients' selection in the scarcity of resources in the COVID-19 pandemic in a communal culture

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Abstract

The scarcity of resources during the COVID-19 pandemic caused ethical dilemmas in prioritizing patients for treatment. Medical and ethical guidance only emphasizes clinical procedures but does not consider the sociocultural aspect. This study explored the perception of former COVID-19 patients and their families on the decision-making process of the patient's selection at a time of scarcity of resources. The result will inform the development of an ethical guide for allocating scarce resources that aligns with Indonesian culture. We conducted qualitative research with in-depth interviews between May - December 2022 involving sixteen participants from various cities in Indonesia. We transcribed the interviews and analyzed the results using thematic analysis. This study found that doctor's decisions often differed from patient's expectations in allocating scarce resources, and therefore, it should be communicated appropriately. Medical decisions were not sufficiently made ethically, but must also be made communicatively. In Indonesia's strong communal culture, community involvement was essential to distributing limited resources. A better approach to ethical education, including adequate communication skills, is necessary to prepare health professionals for facing unpredictable future pandemics.

KEYWORDS
communal culture, ethical dilemma, patient's perspectives, scarcity of resources

1 | INTRODUCTION

Since 2019, the whole world has been shaken by the COVID-19 pandemic, which has affected various aspects of life, including health.[1] The number of COVID-19 patients far exceeded the availability of resources, namely health workers, treatment rooms, medical equipment, and medication, as a result many patients were not treated properly.[2] When the number of patients exceeds the available resources, a limited selection of patients will receive service first. In this case, ethical dilemmas often arise.[3] Allocating resources does not mean prioritizing certain patients and leaving others behind, but looking for strategic steps to provide health services. Therefore,

[1]Gilardino, R. (2020). Does "Flattening the Curve" Affect Critical Care Services Delivery for COVID-19? A Global Health Perspective. International Journal of Health Policy and Management. 9(12), 503.

[2]Atalan, A. (2020). Is the lockdown important to prevent the COVID-19 pandemic? Effects on psychology, environment and economy-perspective. Annals of Medicine and Surgery. 56, 38–42.

[3]Robert, R., Kentish-Barnes, N., Boyer, A., Laurent, A., Azoulay, E., & Reignier, J. (2020). Ethical dilemmas due to the Covid-19 pandemic. Annals of Intensive Care. 10(1), 84–92.

health professionals should maintain bioethical principles in resource allocation to respect the dignity of patients as well as their rights.

According to Beauchamp and Childress,[4] there are four bioethics principles: respect for autonomy, beneficence, non-maleficence, and justice. Respect for autonomy means respecting the patient's rights and freedom to decide about the treatment that will apply to him/her. Beneficence describes the idea that all actions of doctors towards patients must be for the good or interests of the patient, while non-maleficence means not doing actions that are harmful to patients. Finally, applying justice refers to caring for patients without discrimination and maintaining fairness to related parties. These four principles form the basis for health professionals in providing health services, including allocating resources.

One of the guidelines for allocating resources that is in line with these four bioethical principles is recommended by Emanuel et al.[5] This guideline includes optimizing benefits, providing fair treatment, giving priority to health professionals or people with instrumental value, and giving priority to vulnerable people. These principles not only discuss the number of patients which can be helped but also address the need of optimal care. Thus, when health resources are scarce, such as during a pandemic, doctors must choose those who are in greatest need according to medical and ethical indication. The criteria for helping patients must be constantly revisited. In extraordinary conditions, for example, end-stage patients, therapy will not significantly impact recovery because life expectancy is low. Thus, aid and health resources will be optimal if given to patients with greater life expectancy.[6] In this case, ethical dilemmas can arise for health workers, for instance because feelings of guilt and pressure can come up when having to choose patients.[7,8]

This also relates to prioritizing vulnerable people in health services. Vulnerability is highly contextual. When resources are available in a non-emergency setting, vulnerability usually applies to elderly people or children, as could be seen in distribution of the COVID-19 vaccination. Meanwhile, in stages of emergency, when the number of patients exceeds the amount of equipment or treatment available, patients with greater life expectancy should be a priority to maximize the benefit.[9] This principle is closely related to justice. Justice does not only refer to being free from discrimination in serving patients but also addresses the correct use of resources for suitable patients. In conditions of scarcity of resources, justice does not mean that patients who come first will be treated first, a more relevant criterion to ensure justice in treating patients is their health condition.[10,11] A study conducted by Anahideh, Kang and Nezami [12] used empirical research and algorithms to define equity in the distribution of scarce resources, finding that geographic conditions and the vulnerability of social groups affect equity. The article provided an example of equity in providing COVID-19 vaccinations with limited resources. Equity was not determined by vaccination coverage but by fairness in its distribution. Even though a country has high vaccination coverage, if a certain community did not get the vaccine - for instance due to limited access then equity has not been achieved.

While Emanuel et al.'s[13] guidelines are comprehensive, they originate from Western culture. According to Hofstede et al.,[14] most Eastern countries, including Indonesia, have a strong communal culture. Communal culture has the characteristic of being very concerned about the interests of the community. The role of relations within the community is crucial and often impact decisions. This also includes the communication between doctors and patients or patient's families. Additionally, the community can strongly support the individual.[15] Considering these differences, an ethical guide that is patient-centred and tailored to the Eastern cultural context is urgently necessary. A study conducted in Thailand found that there were three criteria for selecting patients in situations of resource scarcity: short-term clinical prognosis, long-term survival, and prioritization of the patient with higher social utility.[16] In Indonesia, guidelines for the clinical care of COVID-19 patients are available, but there are no specific ethical guidelines adapted to the Indonesian culture. In order to develop a patient-centred ethical guideline tailored to Indonesian culture, there is a need for giving voice to non-health professionals, including patient or patient's families who have suffered from COVID-19 or have cared for COVID-19 patients. In Indonesian culture, the family has an important role in patient care and the decision-making process of patient treatment, so that the perspectives of the patient's family has equal value to that of the patients.[17] Therefore, this study explored the perception of patients and their families on the following issues:

[4]Beauchamp, T., & Childress, J. (2019). Principles of Biomedical Ethics (8th ed.). Oxford University Press.
[5]Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., Zhang, C., Boyle, C., Smith, M., & Phillips, J. P. (2020). Fair Allocation of Scarce Medical Resources in the Time of Covid-19. New England Journal of Medicine. 382(21), 2049–2055.
[6]Donkers, M. A., Gilissen, V. J. H. S., Candel, M. J. J. M., van Dijk, N. M., Kling, H., Heijnen-Panis, R., Pragt, E., van der Horst, I., Pronk, S. A., & van Mook, W. N. K. A. (2021). Moral distress and ethical climate in intensive care medicine during COVID-19: a nationwide study. BMC Medical Ethics. 22, 73.
[7]Lacy, B. E., & Chan, J. L. (2018). Physician Burnout: The Hidden Health Care Crisis. Clinical Gastroenterology and Hepatology. 16(1), 311–317.
[8]Truog, R. D., Mitchell, C., & Daley, G. Q. (2020). The Toughest Triage — Allocating Ventilators in a Pandemic. New England Journal of Medicine. 382(21), 1973–1975.
[9]Donkers, et al., op. cit. note 6, p. 73.
[10]Cappelen, A. W., & Norheim, O. F. (2006). Responsibility, fairness and rationing in health care. Health Policy. 76(3), 312–319.
[11]White, D. B., & Lo, B. (2020). A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic. JAMA. 323(18), 1773–1774.
[12]Anahideh, H., Kang, L., & Nezami, N. (2022). Fair and diverse allocation of scarce resources. Socio-Economic Planning Sciences. 80, 101193.
[13]Emanuel, et al., op. cit. note 5.
[14]Hofstede, G., Hofstede, G. J., & Minkov, M. M. (2010). Cultures and organizations, software of the mind, intercultural cooperation and its importance for survival. (3rd ed.). New York: McGraw-Hill.
[15]Osuji, P. (2018). Relational Autonomy in Informed Consent (RAIC) as an Ethics of Care Approach to the Concept of Informed Consent. Medicine, Health Care and Philosophy. 21(1), 101–111.
[16]Marshall, A. I., Archer, R., Witthayapipopsakul, W., Sirison, K., Chotchoungchatchai, S., Pisit Sriakkpokin, Srisookwatana, O., Teerawattananon, Y., & Tangcharoensathien, V. (2021). Developing a Thai national critical care allocation guideline during the COVID-19 pandemic: a rapid review and stakeholder consultation. Health Research Policy and Systems. 19, 47.
[17]Syah, N. A., Claramita, M., Susilo, A. P., & Cilliers, F. (2022). Culture and Learning. In M. Claramita, A. Findyartini, D. D.Samarasekera, & H. Nishigori (eds.), Challenge and Opportunities in Health Professions Education. Springer Nature Singapore.

(1) What are the appropriate ethical criteria for patient selection during the COVID-19 pandemic when resources were scarce according to patients and their families?
(2) How does communal culture in the Indonesian context influence these criteria?
(3) How can health professionals be trained/prepared to be able to provide patient-centred care in future pandemics when resources are scarce?

2 | MATERIALS AND METHODS

2.1 | Research design and data collection approach

This research used a constructivist research paradigm with a grounded theory approach. We conducted semi-structured interviews with 16 participants using an interview guide (see Appendix 1) in the time period of May 2022 until December 2022. There are three parts in the interview guide, namely the participants' opinions on the actions they would take if they became doctors when facing a situation of limited resources during the COVID-19 pandemic, the influence of collectivist culture during the COVID-19 pandemic, and what competences doctors should have in dealing with the dilemma of limited resources. Participants were also given the opportunity to explain the reasons underlying their choice. An advantage of using semi-structured interviews is that the researcher generally has a control over the course of the interview, while participants are welcomed to share their perspectives on topics. Participants were selected using the inclusion criteria of someone who had suffered from or cared for patients with COVID-19. Participants expressed their prior consent to participate in this research. The selection of participants was based on the snowball method. In the snowball method, participants recommended other next participants. Snowball sampling was useful in this case as it simplified the complex and often timely process of finding suitable participants for a study. Access to get patient data from hospitals required complex procedures and it would open the confidentiality of the patient. If participants obtained through recommendations from other participants, this was more useful and it could be valuable in gathering data that is more personal. The snowball continued to roll until data saturation is reached. Regarding sample size in qualitative research, there is no clear agreement among experts regarding the number of participants needed. Therefore, interviews were conducted until 'saturation' was reached. Saturation occurs when "new data can confirm the theory used without actually adding new ideas or insights compared to previously discovered data".[18] Interviews were conducted online so that variations in locations did not become an obstacle for the interview.

[18]Bourgeault, I., Dingwall, R., & De Vries, R. (2010). The SAGE Handbook of Qualitative Methods in Health Research. London: SAGE Publications Ltd.

2.2 | Data analysis and presentation

Interviews were recorded with the permission of the participants and transcribed. The data was kept securely by the researchers to ensure participants' confidentiality. We used thematic analysis approach for the data analysis, because by using thematic analysis approach, we could do categorizing and coding the data and thinking about how the codes relate to each. With thematic analysis, we could understand data about the experiences and thoughts of the participants, then answered the research questions.[19]

Ervin Dyah Ayu Masita Dewi, Astrid Pratidina Susilo, and Lara Matter conducted open coding independently based on the interviews of the first three participants, then discussed the analysis and developed the coding categories collectively. This measure served as a triangulation of researchers. After the coding categories were developed, researchers coded the rest of the transcript independently. The analysis process continued iteratively, and the emerging themes were discussed among all researchers. Finally, data and conclusions were presented in a narrative manner. In addition to the triangulation, we also ensured rigor in this research using several approaches. In the beginning of the study, researchers conducted bracketing to become aware of researchers' own perceptions. During this research process, we continued to reflect to prevent researcher bias. Bracketing, reflection, and researcher triangulation were carried out as an effort to increase the rigor and validity of the research.[20] All of these processes were conducted by maintaining the privacy and confidentiality of research data.

2.3 | Ethical consideration

This research obtained ethical clearance from the Health Research Ethical Committee of Universitas Surabaya (No. 75/KE/V/2022). All participation was voluntary. Participants signed informed consent form after receiving adequate information from the researcher team. We maintained anonymity and confidentiality of the participants throughout the research process and the publication.

3 | RESULTS

3.1 | Participant demographic data

Table 1 presents the characteristics of the participants. There were 16 participants (9 men and 7 women) aged 21-71 years who had suffered from COVID-19 or treated family members with COVID-19. The participants had various occupational backgrounds: teachers,

[19]Kiger, M., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. Medical Teacher. 42(8), 846–854.
[20]Cypress B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. Dimensions of Critical Care Nursing. 36(4), 253–263.

TABLE 1 Participants' Characteristics.

Participant	Age	Sex	Occupation	Region
Participant 1	39	Male	Teacher	Surabaya, East Java
Participant 2	46	Male	Private employee	Depok, West Java
Participant 3	46	Female	Housewife	Depok, West Java
Participant 4	38	Male	Private employee	Malang, East Java
Participant 5	38	Female	Government employee	Malang, East Java
Participant 6	47	Female	Teacher	Sidoarjo, East Java
Participant 7	48	Female	Private employee	Surabaya, East Java
Participant 8	46	Male	Entrepreneur	Surabaya, East Java
Participant 9	47	Male	Entrepreneur	Surabaya, East Java
Participant 10	47	Male	Businessman	Samarinda, East Kalimantan
Participant 11	46	Female	Private employee	Samarinda, East Kalimantan
Participant 12	31	Male	Private employee	Madura, East Java
Participant 13	54	Male	Private employee	Surabaya, East Java
Participant 14	71	Male	Government employee (retired)	Jakarta
Participant 15	62	Female	Housewife	Jakarta
Participant 16	21	Female	Student	Lampung

private employees, government employees, housewives, and retired employees. Participants come from various regions in Indonesia with different geographical conditions, cultures, and values in life. The demographic diversity enriches research data because Indonesia has a varied culture that influences many aspects of life, including health.

Three themes emerged from the analysis: (1) the variation in the participants' perceptions of the patient selection, (2) the strong demand for health professional communication skills, and (3) the initiative of the community to support each other during the pandemic. We elaborate on each theme below and provide examples of quotes from the interviews.

3.2 | Theme 1. The variation in the participants' perceptions of the patient selection

The participants reported that the conditions of the COVID-19 pandemic caused limited resources in all places. The health sector was not ready to manage and allocate limited resources, especially at the start of the pandemic. The participants perceived that doctors did not have guidelines on the criteria for selecting patients to be treated when the number of patients exceeded the number of treatment facilities. We found four criteria for patient selection based on the perspective of the participants as non-health professionals: the severity of the illness and life expectancy, age and vulnerability, the patient's instrumental value in society, and finally, the relationship between patient and doctor.

All participants thought that patients with more severe conditions should be prioritized for treatment first.

> "The priority is to treat patients with life-threatening conditions". (Participant 1).

Whereas with several patients with the same emergency condition, they said that vulnerable groups, such as the elderly and children, should be a priority, rather than young people. These vulnerable groups need assistance managing their health, so they must be a priority when health resources were scarce. Participant 7 said,

> "I will choose the older patient. Because physically he may need more effort and the younger one has a better immune system".

Another participant connected the obligation to put parents first as part of God's commandment,

> "So, I myself respect elders just like my parents. By doing this, I believe that God will love us more." (Participant 9).

Other participants chose to prioritize their parents because it was related to the local culture, which it is important to respect parents. Participant 2 argued that

> "Indonesia is part of the Eastern area in the whole world, in the Eastern culture people pay more respect to the elderly people."

Also, Participant 9 added,

> "For us, in Indonesia, there is some kind of culture to follow, so the elders must be helped or treated first."

This finding is striking because the selection of the elderly as a priority group to receive care when there are not enough resources for every patient is influenced by the local culture and moral values shared by the participants. However, there was one participant who had a different answer. Although culturally, he had to give priority to the elderly, he rationally chose young patients because their life expectancy was longer. This should be noted because rational considerations could outweigh cultural considerations for some people.

The patient's instrumental value in the context of the pandemic was also a priority consideration for the patient. The instrumental values were not based on the social position of the patient in the community but on the patient's roles or occupation, which could be beneficial to the community in case the patient recovered instance, priority should be granted to patients who can help more people recover, such as doctors or other health workers.

> "I'm usually a bit hesitant to choose based on what their occupation is. I rather, you know, choose based on the underlying condition. Basically, in this situation, you know, if you can save a doctor which can also help you in the future safe another patient. It is probably going to be one of the…what do you say…one of the criteria that we can think about." (Participant 8)

Participant 1 also said,

> "The doctors must be helped because when they recover, they can help others."

Furthermore, several participants argued that this instrumental value can be indirectly related to the patients. For example, an illness of a family member can make a health professional worried and distracted. Therefore, to help the health professional keep working well, it was necessary to prioritize the family member. Participant 15 said,

> "It may seem unfair, but if a doctor prioritizes other people over his family, it will definitely distract the doctor. He has to help others while his family has not obtained help. Yes, it can be considered that family of doctors who need ICU are also a priority so that doctors can concentrate on working on treating other patients."

Nevertheless, Participant 15 admitted that he might feel disappointed if the doctors prioritized their families over other patients. However, he could understand as he would do the same if he were in the doctor's position. A similar viewpoint was given by participant 4,

> "Doctors are also human who have empathy and I would do the same if I were in their shoes."

Additionally, social and kinship relationships were also criteria for patient selection. Participant 8 explained,

> "If you're in a good relationship with someone you're probably going to treat that person first, rather than somebody you don't know. So, I think it is just human nature that you probably want to see somebody you know, you want to help somebody you know more than helping someone you don't know."

Participant 7 also had similar notions,

> "I would help my neighbour first due to emotional bond. If we knew each other, there is a will to help the one that you know."

This relationship was mainly due to cultural factors, which considered the people we know to get help first, which was seen as natural. Several participants expressed this notion; for example, Participant 9 stated,

> "Culture is one of the factors that strengthened this choice. In my city, neighbours are one of our closest relatives. They are considered as our relatives, so it is natural for us to choose to save them or treat them"

These opinions reflected the collectivist cultural orientation of people in Indonesia, which also made them understand the doctor's considerations prioritizing their families before other patients if both were in a similar health condition. From several findings regarding the criteria for selecting these patients, it appears that participants will generally prioritize patients whose health conditions are more serious/life-threatening, then prioritize elderly/vulnerable patients while still paying attention to kinship and social functioning of patients when they have recovered. These criteria are influenced by the moral values that participants believe in, which are shaped by the prevailing local culture. In this case, for instance, the value of the collective is reflected in the participants' decision to prioritise people that have a social function within the community.

3.3 | Theme 2. The strong demand for health professionals' communication skills

When resources were scarce, participants realized that it was not easy for health professionals to allocate resources and select patients to be treated. Whatever the doctor's decision, the participants believed that the doctor had well-thought and specific considerations, and the patient respected them. Patients trusted doctors because doctors could see their patients' conditions well,

> "Because as a patient, we don't mind others' business. We do not know how bad their condition was. But, as a doctor we are seeing it globally (Participant 10).

However, the challenge was how the doctor conveyed the decision to the patient, for example, when the doctor refused a patient because the treatment room was fully occupied. Participant 6 underlined the importance to communicate doctors' choices,

> "I think communication is important in that condition, especially when the patient's family is panicked. So, the health professionals must certainly explain to the family the reasons behind the choices and the priorities made by the health workers so that we can accept it."

If doctors could not communicate well why some patients were not admitted to the hospital, the patient or the family might be disappointed and develop a prejudice,

> "The family felt disappointed, or any bad thoughts. Was it because I don't have money? People may think as they please, why they didn't get treated that well, why they couldn't get this or that" (Participant 11).

Therefore, participants agreed that health professionals should possess strong communication skills besides medical knowledge. Doctors must follow procedures but should still have to respect patients, especially in terms of how to provide information. Participant 2 explained,

> "If we're talking about how to communicate, how to deliver ideas or information to other people or patients or the patient's family, they're crying enough to bring their family members to the hospital, we cannot just explain about the mechanism, about the Standard Operational Procedure but we can also help deliver the message. Not just the message itself but also how to deliver; that is the most important. Because that is the way, you make people understand."

Participants suggested that to have good communication skills, health professionals should have specific communication training.

3.4 | Theme 3. The initiative of the community to support each other during the pandemic

During the peak of the COVID-19 pandemic, all participants reported difficulties accessing medicine, hospital care, and supporting materials such as oxygen. Resources were limited throughout all of Indonesia, and the existing healthcare system could not provide all services during the pandemic. However, participants said that the role of the community immensely helped them. Neighbours and friends helped them access treatment, medicine, and medical devices.

> "In my neighbourhood, we had oxygen from the non-medical workers. At that time we were short of oxygen, so I tried to initiate the community. We did this by collecting money voluntarily to buy oxygen. We also cooperated with the doctors in our neighbourhood and talked to them about what we must do during the pandemic for first aid." (Participant 9)

Community involvement was essential to help distribute medical devices. Some people in the community were willing to spend personal money to help others. According to one participant, this phenomenon was influenced by Indonesian culture, which considers neighbours or communities to be brothers and sisters and, therefore, must be helped. There were several initiatives at the grassroots level to organize community involvement so that people could help each other more effectively.

> "In Indonesia a neighbourhood has like a smaller unit, a unit has around 20 households each have somebody called RT. It is somebody who is not part of a government but something like that. Then, a few small units have one more unit, a head of the unit up to city level" (Participant 8).

RT is the abbreviation of *'Rukun Tetangga*,' which means a harmonious neighbourhood, usually led by a community member voluntarily. According to the participants, an alternative approach to the distribution of limited resources is to involve the community/society through good coordination with the government. For example, Participant 4 suggested this,

> "I think it is a good idea as long as it happens in a clear commando under the coordination of the authorities so that we prevent hoarding. So, during the pandemic, we need lots of resources, so the community is really helpful, so the distribution goes faster."

4 | DISCUSSION

This study aimed to explore the views of non-health professionals regarding the criteria of patient selection during the COVID-19 pandemic and the necessary preparations for health professionals to face the challenging situation. Although the criteria of selection vary, our participants agreed that the allocation of resources should be conducted fairly, with the priority on patients whose conditions were more life-threatening and vulnerable, while paying attention to

the magnitude of the benefits obtained, which were also related to the patients' life expectancy.

Consideration of life-threatening conditions is also a priority that exceeds the criteria for 'first come, first served'.[21] The awareness that it is not always the patients who arrive first who receive treatment, but also considering the health condition, shows that the patient can understand the doctors' points of views. In addition, the patient's instrumental value can also be a consideration because prioritizing these patients will help more people later. Therefore, we argue that in the Indonesian context, the bioethical principles from Beauchamp and Childress that is described by Emanuel et al. is relevant and can serve as a recommendation for health professionals in determining the criteria for selecting patients to be treated when resources are limited.[22] The beneficence principle explains that we have to protect and defend the rights of others. Everyone has the right to be saved. Although in conditions of resource scarcity, beneficence must be understood as providing the maximum benefit in accordance with appropriate proportions. The benefits given to patients who are suffering from a terminal illness are different from the benefits given to patients with a greater life expectancy. In this situation, the principle of beneficence is also closely related to the principle of justice. Justice in the context of equity and beneficence is giving others what they are entitled to according to the greatest benefit they can receive. In conditions of limited resources, prioritizing providing assistance to patients who have a greater life expectancy can be said to be fair and in accordance with ethical principles. Thus, doctors must understand the criteria for patients who are vulnerable and have a greater chance of being prioritized.[23]

Nevertheless, there were some findings that may be perceived as contradictory to the guides in Western culture, for example Emanuel's recommendation.[24] First, regarding vulnerable people, further research is necessary to explore whether health professionals and lay people have the same understanding of the concept of vulnerability. Vulnerability for doctors is contextual, while participants of our study mainly referred to the elderly and children as vulnerable populations. In selecting patients during a time with limited resources, this difference in perception between doctors and patients can lead to conflict because patients think doctors do not respect the patient's understanding of the vulnerable.[25]

Second, Eastern culture and religious teachings in Indonesia demand to prioritize the elderly, especially parents.[26] It means that negligence in doing so is considered a sin. This issue becomes an ethical dilemma for doctors when dealing with elderly patients. When doctors prioritize younger patients that have greater chances to live or recover, society may assume that doctors do not have respect for elderly. The community understands that doctors have medical guidance but hope that the elderly can be prioritized.

Third, in some cases, the family of health professionals is prioritized over unknown patients if the severity of the patients' conditions is the same. This choice does not mean to discriminate, but if the families of medical personnel do not receive treatment, it can influence the concentration of medical personnel at work, which will undoubtedly disrupt services to other patients as well. The application of the principles of bioethics contained in the Indonesian Code of Medical Ethics, in the context of a pandemic, means that consideration of prioritizing the family of health professionals to keep the doctor's concentration at work is acceptable if this is the best and most beneficial option, for instance because if the doctor's concentration is disturbed, it will bring harm to more patients.[27] Eastern culture seems to reinforce this consideration, that as part of their family, doctors must care for their family. This idea highlights Indonesia's communal culture, which welcomes prioritization of known groups.[28,29]

An interesting finding from this study was that the participants highlighted not only the basis doctors use in making decisions when resources are scarce, but also the way doctors convey these decisions. Participants hope that doctors can show empathy and respect the patient's right to obtain information. However, managing communication is often an obstacle for doctors in providing health services. The perception of doctors and patients that are not always the same is one factor contributing to the inadequacy of information from doctors to patients and their families. In addition, the skills of doctors in information disclosure are also often not in line with patient expectations. Doctors with limited time to give information to patients often give incomplete or rushed explanations. As a result, patients and families, disappointed because they did not receive treatment due to scarcity, felt they were not getting enough information and may have misunderstood the doctor's intentions.

In informed consent, four components must be present: patient competency, information disclosure from doctors, comprehension of the patient, and voluntariness of the patient's decision.[30] If the doctor conveys complete information but in a way that is unacceptable to the patient, then the patient will also not understand the doctor's information. According to the findings in this study, in conditions of scarce resources, patients want a good explanation from the doctor before the doctor gives a recommendation for intensive care, referral to another hospital, or receiving palliative care. Ethical decisions must be conveyed communicatively to patients and their families so that they can be accepted. Unfortunately, these communication skills are often not a priority in medical education or are challenging to be

[21]Yip, J. Y.-C. (2021). Healthcare resource allocation in the COVID-19 pandemic: Ethical considerations from the perspective of distributive justice within public health. Public Health in Practice. 2, 100111.
[22]Emanuel, et al., op. cit. note 5.
[23]Cypress, op. cit. note 20.
[24]Emanuel, et al., op. cit. note 5.
[25]Donkers, et al., op. cit. note 6.
[26]Hofstede, et al., op. cit. note 14.
[27]Purwadianto, A., Soetedjo, Gunawan, S., Yuli Budiningsih, Pukovisa Prawiroharjo, & Firmansyah, A. (2012). Indonesian code of medical ethics. Indonesian Doctors Association.
[28]Syah, et al., op. cit. note 17.
[29]Hofstede, et al., op. cit. note 14.
[30]Faden, R., & Beauchamp, T. (1986). A history and theory of informed consent. Oxford University Press.

taught by teachers.[31] Therefore, communication skills are needed for health professionals and students while they are still in medical education and as continuous professional development.

Finally, when the existing healthcare system failed to provide service when the resources were scarce, community involvement played essential roles. This study found that participants received help from neighbours or friends to get medication or medical equipment during the pandemic. The RT (*Rukun Tetangga*) played essential roles as a well-organized multilevel community starting from several households. We believe that this is a manifestation of the communal culture that brings many benefits to society. The high solidarity within the community solved problems more effectively. The social networks one has is also helpful for others.

However, the communal culture also brings an ethical challenge in the context of scarcity of resources. Sometimes, health professionals prioritize the group's interests, and people who are not part of the group are left behind. This is often called the 'in-group and out-group phenomenon.[32] Thus, justice becomes a challenge in this culture. For example, someone who is known but has a more negligible medical risk can obtain treatment earlier than someone who is in a more serious condition but is not known. Health professionals who live in a communal culture have the same challenges. For instance, when a doctor does not prioritize serving a relative, culturally, his or her solidarity is questioned. From the patients' perceptions in this study, participants thought that doctors should prioritize patients who are their neighbours or relatives if their health conditions are the same as previously unknown patients. Nevertheless, the patient selection criteria are contextual according to the patient's condition and the availability of resources. This selection must be wise to avoid subjectivity from medical personnel, which can lead to injustice. The risk of a doctor choosing a patient can arise due to feelings or subjectivity because of a social relationship. If the doctor's family is sick, it will create a dilemma for the doctor. Doctors can lose concentration at work because apart from taking care of patients, they also have to take care of their families who have not received medical care.

For this reason, an ethical guide is essential for health professionals in making decisions. The government or health institutions must provide ethical guidelines in allocating limited resources, not only guidelines in clinical care.[33] Doctors must always prioritize the principles of bioethics, respect for autonomy, beneficence, non-maleficence, and justice. Prioritizing relationships is still tolerated as long as it does not bring greater harm to other patients.[34,35] With community involvement in Indonesian communal culture, doctors should also be aware that clinical ethics cannot be applied only on a doctor-patient level but also on the community level. In Indonesian communal and religious culture, a medical decision is considered ethical or not, not only by medical or ethical professionals, but also by the local social culture. This culturally influenced ethical principle forces doctors to consider the values of society.[36] In conditions of scarcity of resources, doctors cannot only think about treating a patient but, with limited resources, also think about effective treatment that brings more significant benefits to society, for example, by considering the patient's instrumental value. Dunham et al.[37] also recommend using public health ethics as an addition to clinical ethics in allocating limited resources.[38] With this awareness, doctors consider patients not only as individuals but as part of a community. Doctors not only communicate with patients but must also be able to communicate with the patient's family or the community that accompanies the patients.[39]

This communication also brings challenges for doctors. From the research of Wang et al.,[40] for doctors, patient-centred communication affects the good doctor-patient relationship. As for patients, it also acts as a mediator between doctors and patients, and increases patient trust in doctors. Susilo et al.[41] said that health professionals are negotiators in the informed consent process that must master communication skills. The findings of this study further emphasise this. Therefore, communication skills are essential in serving patients, especially in conditions of communal Indonesian culture. It will be beneficial for doctor-patient relationships, especially in conditions of limited resources, to avoid misunderstandings.[42,43]

4.1 | Limitations of the study

This study was conducted online and therefore participants required stable internet connection and a device that they could log in with. These two requirements may have resulted in an exclusion of people who had less digital literacy or who did not have internet connection.[44]

[31]Claramita, M., Susilo, A. P., Kharismayekti, M., van Dalen, J., & van der Vleuten, C. (2013). Introducing a Partnership Doctor-Patient Communication Guide for Teachers in the Culturally Hierarchical Context of Indonesia. Education for Health. 26(3), 147–155.
[32]Hofstede, et al., op. cit. note 14.
[33]Matheny Antommaria, A. H., Gibb, T. S., McGuire, A. L., Wolpe, P. R., Wynia, M. K., Applewhite, M. K., Caplan, A., Diekema, D. S., Hester, D. M., Lehmann, L. S., McLeod-Sordjan, R., Schiff, T., Tabor, H. K., Wieten, S. E., & Eberl, J. T. (2020). Ventilator triage policies during the COVID-19 pandemic at U.S. hospitals associated with members of the Association of Bioethics program directors. Annals of Internal Medicine. 173(3), 188–194.
[34]Beauchamp & Childress, op. cit. note 4.
[35]Bertens, K. (2011). Etika Biomedis. Kanisius.
[36]Mulyana, D., & Ganiem, L. M. (2021). Komunikasi Kesehatan Pendekatan Antarbudaya. In D. Feirus (ed.). Kencana.
[37]Dunham, A. M., Rieder, T. N., & Humbyrd, C. J. (2020). A Bioethical Perspective for Navigating Moral Dilemmas Amidst the COVID-19 Pandemic. The Journal of the American Academy of Orthopaedic Surgeons. 28(11), 471–476.
[38]Ibid.
[39]Claramita, M., Utarini, A., Soebono, H., van Dalen, J., & van der Vleuten, C. (2011). Doctor-patient communication in a Southeast Asian setting: The conflict between ideal and reality. Advances in Health Sciences Education. 16(1), 69–80.
[40]Wang, Y., Wu, Q., Wang, Y., & Wang, P. (2022). The effect of Physicians' Communication and Empathy Ability on Physician-Patient Relationship from Physicians and Patients Perspectives. Journal of Clinical Psychology in Medical Setting. 29(4), 849–860.
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[42]Dewi, E. D. A. M., Sastrowijoto, S., & Padmawati, R. S. (2021). Autonomous Informed Consent in Term of Completeness of Medical Information Disclosure. BKM Public Health and Community Medicine. 37(3), 71–78.
[43]Truog, et al., op. cit. note 8.
[44]Keen, S., Lomeli-Rodriguez, M., & Joffe, H. (2022). From Challenge to Opportunity: Virtual Qualitative Research During COVID-19 and Beyond. International Journal of Qualitative Methods. 21.

5 | CONCLUSIONS AND RECOMMENDATION

In conditions of scarcity of resources, for example, during the COVID-19 pandemic, guidelines are needed to select patients who will receive treatment according to the availability of resources. Based on research findings adjusted for related references, the main criteria remain the patient's medical condition and life expectancy, but the patient's instrumental value and the role of the community must also be considered. In Indonesia's communal culture, the role of the community is very helpful in the distribution of resources. The government can optimize this by better organizing the community. Physicians' decisions in allocating resources and selecting patients must be based on ethical considerations of respect for autonomy, beneficence, non-maleficence, and justice. Health professionals should master adequate communication skills individually to patients and consider their families and communities. Unfortunately, ethics and communication education have not received much attention in the medical education curriculum in Indonesia, and therefore there is a need for better integrating communication skills into the education of health professionals. In Indonesia, there are not any specific ethical guidelines adapted to eastern communal culture related to resource allocation.

Based on the results of this study and analysis of related references, we recommend aspects that doctors/medical personnel need to do or improve in allocating resources that are ethically appropriate to Indonesian culture:

- Integrating communication skills and bioethics in the health professions education curricula.
- Improving communication skills beyond the patient and family, considering that patient lives within the community.
- Continuing professional development of doctors held by medical, educational institutions, and medical professional organizations on a regular and ongoing basis.

We also recommend further studies regarding the development of ethical guidelines adapted to the Indonesian cultural context, by exploring the health professional views.

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CONFLICT OF INTEREST STATEMENT

We declare no conflict of interest related to this study.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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