Young Medical Doctors' Perspectives on Professionalism: A Qualitative Study Conducted in Public Hospitals in Pakistan

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Abstract

Background: Professionalism is amongst the major dimensions indicating the competence of medical doctors. A decline in professionalism affects the overall outcome of healthcare services. This study explores the patterns of declining professionalism among young medical doctors in Pakistan.

Methods: A qualitative study based on in-depth interviews was conducted with 60 young medical doctors aged less than 40 years who were employed at various levels from house officer to consultant specialist in public tertiary hospitals in Pakistan. The respondents were identified through a multistage maximum heterogeneity sampling strategy. A semi-structured interview guide was developed based on a previous extensive literature review. Written consent was obtained from the hospitals and study participants. Thematic content analysis was applied to analyse the data.

Results: The data analysis revealed a rigidity of opinions, inflexibility blocking the acceptance of contrasting perspectives, and perceived superiority over all other professions and over patients. The belief that patients know nothing was common among all participants. Similarly, doctors believed that there is no need to include a professionalism and humanity course in the medical school curriculum. The majority of respondents thought that social science topics are irrelevant to medicine and are common-sense things that they already know. The doctors recognised high professionalism in themselves, while reporting unprofessional behaviour demonstrated by their colleagues. The reported characteristics include using social media applications during duty hours, ridiculing patients, substance use such as cigarettes in the office, referrals of complicated cases to other hospitals, freeing up beds before holidays and inappropriate salaries.

Conclusions: It seems that professionalism has declined among young doctors, and this should be immediately addressed by policymakers. The lack of training about ethics and healthcare service delivery, and a lack of performance monitoring and evaluation mechanisms at public hospitals are the major factors contributing to declining professionalism. There is a need to revisit the curriculum taught to medical students in order to strengthen professionalism.

Background

Medical professionalism is one of the key components of the doctor’s toolkit, and comprises technical expertise, interpersonal skills, time management skills, and medical competence. Clinical excellence cannot be achieved unless a doctor has high personal values such as altruism, empathy, respect for human life and good conduct (1). Professionalism can be defined as a set of attitudes and behaviours that serve as the foundation for services rendered by an individual towards society (2). Six components of medical professionalism have been suggested: excellence, self-denial, accountability, duty, rectitude, and respect (3). Empathy towards patients may be defined as the ability to understand a patient’s perspective and support him or her (4). Scholars have concluded that empathy may diminish among doctors due to their mistreatment by seniors and impersonal associations with patient subjects during

their time at medical school, which is a threat to their professionalism and the overall quality of healthcare (5).

Medical professionalism is a belief system in which professionals promise to uphold in their work an adherence to ethical principles and respect for human diversity (6, 7). Lack of professionalism is connected to irresponsibility, procedural errors, conflict within medical teams, and concerns about profit (8). International studies have demonstrated that professionalism is an important quality when identifying a good doctor, along with technical and non-technical skills (9).

The health services in wealthier countries have progressed away from a traditionally paternalistic approach towards a more patient-centred and egalitarian, collaborative approach to doctor-patient relationships (10). However, healthcare providers, specifically medical doctors in public health systems, in developing countries such as Pakistan have been resistant to accepting the validity of modern approaches towards determining the doctor-patient relationship (11). This is associated with the declining medical professionalism among doctors in their early years of professional service.

There has been some debate about the quality of medical graduates over the last two decades and the medical professionalism of young doctors serving in public-sector hospitals in Pakistan. Previous studies on medical professionalism in Pakistan have focused on the qualities a good doctor should possess and have demonstrated that the medical community is trying to respond to this lack by means of conserving, researching, teaching, and evaluating professionalism (12, 13). Young medical graduates have socially constructed attitudes of superiority to other professions, because only the highest performing students in the education system become doctors in Pakistan. Familial pride is associated with their high-performing children when they succeed in qualifying for medical school. This generates a sense of superiority among both medical students and practitioners. The behavioural problems among doctors is also linked to an absence of professional spirit directed towards serving humanity, stubbornness about accepting other points of view, the subjectivity of human nature and breaches of the Hippocratic Oath (14). Furthermore, structural problems such as long working hours, low salaries, and unfavourable working environments have adversely affected medical professionalism.

In developed countries, medical graduates are well trained in using human and professional skills to deal with patients in an empathetic manner (15). However, there is huge variation in the standard of professionalism in developed and underdeveloped countries (16). On the one hand, professional spirit is declining among doctors and, on the other, the previous high opinion of the medical profession among patients is also going through a regressive change.

Scholars have been devising means of improving the professionalism of doctors through teaching additional courses as part of the formal curriculum and introducing training sessions on humanism in medicine. Klemenc-Ketis and Kersnik (17) have experimented with the use of movies to increase the level of professionalism among medical students by depicting ideal situations involving positive behaviour and scenarios of rich resource settings.

In Pakistan, students who demonstrate extraordinary academic performance and are positioned at the top of the merit tables are recruited into the medical profession. After working hard for many years, they remain unpaid or underpaid (18). The struggling doctors in Pakistan are protesting peacefully about the causes of low payment, hectic work schedules and job insecurity (19, 20). Abbasi (18) highlighted that the problems faced by doctors adversely affect the experiences of patients and lead to the departure of highly capable medical doctors from Pakistan. The prolonged suffering, delayed provision of medical care facilities, potential loss of health, lack of job security, unpaid service, and non-recognition of services rendered are the factors associated with strikes by young doctors.

Like other areas of public health, professionalism has also not been extensively explored in Pakistan. Up to now, only one study has focused on professionalism among medical students in Pakistan (12), but no previous work is available that examines professional behaviour among young doctors. Hence, this study aims to: (i) understand the perceptions of young medical doctors regarding how professional they are and how they perceive the structures, processes and outcomes that affect their medical professionalism; (ii) explore the patterns of declining medical professionalism among young doctors in Pakistan; (iii) depict the problems of young medical professionals that hinder their ethical performance, and hence to make result-based recommendations.

Methods

This study is based on interpretive ontological and epistemological foundations. Data was collected through in-depth interviews with 60 young medical doctors. The respondents were identified using a multistage maximum heterogeneity sampling method. In accordance with this method, first of all hospitals were selected, based on the prerequisite that the largest public-sector teaching hospitals in three regions within Pakistan (Sindh, Punjab, and the State of Azad Jammu & Kashmir) be included. The major public-sector, tertiary-care hospitals were sent written requests explaining the purpose of the present research. The study was carried out in the consenting hospitals. The respondents were young doctors (less than 40 years of age) in the early years of their professional careers who were working at various hierarchical levels as house officers, medical officers, trainees, senior registrars and specialists (Table 1).

Table 1

Multistage Maximum Heterogeneity Sample Calculation

Sampling stage 1	**Selection of hospitals**	**Criteria: Largest public-sector teaching hospital in provinces of Sindh, Punjab and the State of Azad Jammu & Kashmir (AJ&K)**	**1 hospital Punjab 1 hospital Sindh 1 hospital AJ&K**
Sampling stage 2	Recruitment of doctors	Criteria: (i) Age: 24 to 32 years / 33 to 40 years (ii) Gender: male / female (iii) Service level: house officer, medical officer, PGT trainee, senior registrar, specialist	Calculating factor: 2 × 2 × 5 = 20 doctors to be selected in each hospital

A semi-structured interview guide was developed based on an extensive literature review. The respondents' profile attributes included: gender, age, nationality, qualifications, designation, area of specialisation, and length of service. The interview guide included open-ended questions about: reason for becoming a doctor; hardships and gratification; understanding of the meaning of professionalism in medicine and qualities of ideal medical doctors; young doctors' perceptions of patients (ridiculing the patient, treating them as subjects, justified misbehaviour, VIP culture in hospitals); perceptions of flawed technical expertise (procedural errors, absence of physical examination, and inability to diagnose without pathology tests); dealing strategically with security issues and safety at work; personality traits (patience, tolerance, flexibility, altruism, service to humanity, high moral standards, integrity, honesty, and duty); process and structural factors hindering professionalism; self-pride and shaming of other professions; and what has to be done to improve the situation.

The interview guide and respondents' answers were all in the English language. The written consent forms were signed by the participants before interviews were conducted. The consent form was developed using the World Health Organization's checklist for English-language consent forms for health services. The methodology of this study was approved by the Institutional Review Board of the International Islamic University, Islamabad. Written permission was obtained from the hospitals where the study was initiated. Since the phenomenon under consideration was sensitive and could have serious implications for the respondents, neither the names of hospitals nor any information that could identify the doctors are disclosed in the paper.

During the initial days of the research, the doctors gave socially desirable answers and were not willing to give much time. After developing a comfortable and trusting environment, discussion was enabled with doctors in multiple sittings. Over the course of several sittings, the doctors shared useful information. The interviews were conducted in their offices during post-duty hours. The data collection was completed during the months of April and May 2019. A qualitative content analysis method was applied to draw out the findings of this study (21). Two researchers performed data analysis in terms of the extraction of

codes, themes and categories. Both, a deductive and inductive approach based on the interview guide and further explanations of study participants was applied.

Results

Indicators of declining professionalism

Rigidity of opinion, inflexibility, and non-acceptance of contrasting perspectives, perceived superiority over all other professions and over patients were linked with declining medical professionalism. Overall, the doctors believed that there is no need for the inclusion of a professionalism and humanity course in the medical school curriculum. The majority of respondents thought that social science topics are irrelevant to medicine and are merely common-sense things that they already know. The doctors recognised high professionalism in themselves while reporting unprofessional behaviour demonstrated by their colleagues. These reported characteristics include using social media applications during duty hours, ridiculing patients, substance use such as cigarettes in the office, referrals of complicated cases to other hospitals, freeing up beds before holidays and inappropriate salaries.

Perceived superiority and paternalistic approach

Some of the doctors became angry during the interview about the subject matter of the research and regarded it as a strategy to make doctors furious. The statement of one respondent may be useful at this point to further clarify the scenario: “I don’t understand why you’re carrying out such research. This is not your field – you’re not a medical doctor. A doctor of medicine can ask us such questions.” Another respondent said: “Because of this type of research, doctors are unable to perform well on duty.” No demonstration of openness was recorded.

All the respondents believed that their knowledge of medicine has equipped doctors with a superior position over their patients and other healthcare service providers. The belief that patients know nothing was common among all the participants. One female doctor said: “A down-to-earth approach wouldn’t work for patients in Pakistan. Patients don’t mind the harsh conversation by the doctors, rather they think that a doctor who snubs is a competent doctor.” Another respondent said: “Patients know nothing irrespective of the fact that he is educated or not – obviously one would not become a doctor by googling diseases and symptoms.” This statement reveals a sense of superiority over patients and other human beings. The doctors demonstrated a lack of any perceived need to establish congruence with patients.

Practising professionalism and training for positivism

Almost all the participants vested medical professionalism in themselves and reported other doctors as having distorted professional ethics. For example, we were told that medical doctors use mobile phones while seeing patients. This is a common practice among doctors in Pakistan, which affects the quality of attention they give to patients. Furthermore, substance use by male doctors in offices has also been reported by female doctors.

Inadequate role models

During the first sessions, the doctors gave socially desirable answers, such as: “We’re very professional and none of the doctors show aggressive behaviour on duty.” However, later on, the respondents emphasised that aggression is a basic part of human nature. In conflict situations, both parties are justified in demonstrating aggressive behaviour.

Seniors and colleagues who are rude and critical and create conflict are just following human nature. No one mentioned controllability. Mistreatment by seniors and a high workload were reported by a few respondents. The seniors should set good examples for the young doctors to follow, said one respondent.

Intermediary non-medical staff

Doctors reported non-cooperation from non-medical staff, especially nursing assistants, during the execution of medical procedures. Due to the status of the job and facilities in the public sector, nursing staff often clash with doctors. Technically, the doctor is head of a healthcare team, but the situation is different in public hospitals in Pakistan. One female trainee doctor said: “We have to call the nurse in a low and sweet tone so she may give us the thing that we need. All of the doctors call the nurse as nurse jee” (in Urdu, jee is used with names to show extreme respect). Patients were told that the nurse in charge is uncooperative. One of the doctors reported that she has heard a nurse saying: “I’m busy now – come tomorrow. I will tell you how to use insulin, diet chart and check blood sugar.”

Ethical service delivery and professionalism

There should be a regulatory authority in hospitals to monitor the flow of activities. It is the professional duty of a doctor to provide palliative care that involves symptomatic treatment alongside psycho-social support for the patient. One male trainee doctor spoke about what professionalism is: “A good doctor sacrifices his sleep and appetite so that his patient could sleep well.”

Only one out of 17 doctors said that he wants to serve humanity and emphasised that the purpose of joining this profession was not the monetary benefits.

Need for accountability and training

The respondents agreed that a mechanism for accountability is required in hospitals, but emphasised the need to appoint a medical doctor with expertise in evaluation. This suggested that medical doctors would not like to be watched by a person with a non-medical background. Even after agreeing about declining professionalism, they did not consider the significance of the non-technical courses (i.e. interpersonal communication, social psychology and professionalism) in their degree programmes. They still viewed it as irrelevant content.

Discussion

This study investigates medical professionalism among young doctors and provides a qualitative analysis of the attitudes of 60 young medical doctors towards professionalism. The results indicate that young doctors lack professional ethics. Even though the profession cultivates humanism, the findings are quite contradictory. The findings of this study question the quality of medical education in Pakistan. Medical students only learn professional values informally because professionalism is still not taught explicitly at medical colleges or medical universities in Pakistan.

In countries like Pakistan, parents always ask their children to opt for medical science as a profession. This is due to the possibilities of getting highly paid jobs and the social prestige attached to this profession. Parents invest heavily in their children's education in order to make it possible for their children to gain admission to medical science courses. Consequently, once a student secures admission to medical college, he/she and his/her family take pride in this achievement. In addition, medical colleges exist in a kind of environment where their students have always been considered more successful than students who are studying in other fields. In such a scenario, medical students feel themselves superior to others, although a lesser amount of money is spent on the healthcare sector, particularly for medicines (22). This is supported by our study results, because the young doctors believe themselves to be a superior person who knows better than patients. Listening to the viewpoints of patients about their health helps doctors to uncover possible reasons for ailments, but doctors' sense of superiority does not allow them to fully understand the condition of patients (11). This is why most young doctors do not achieve the standard of diagnosis that a successful doctor should have.

The success of healthcare procedures depends on cooperation between the entire healthcare team: doctors, nurses and other non-medical staff (23). However, young doctors frequently report non-cooperative behaviour by the non-medical staff. One possible reason for this non-cooperation is that young doctors are not capable enough to express their emotions in a positive manner. Non-medical staff claim that doctors behave rudely towards them. Most doctors do not even know how to treat their subordinates in emergency situations. Not only do they misbehave with their subordinates, but they also have the same attitude towards the patients and their attendants, particularly those who belong to lower social classes (24).

It is required that doctors and nonmedical staff pay full attention to their work while on duty. However, this seems not to be true for young Pakistani doctors. The foremost reason for their lack of seriousness is excessive mobile phone and internet use. Previous work also confirms our finding that the use of mobile phones and social media is quite common among Pakistani doctors during their working hours (25–27). Furthermore, it is extremely alarming that these young doctors do not judge the use of mobile phones and internet during duty hours as being relevant to professionalism.

In our study, the majority of young doctors agreed that professionalism among doctors is declining. However, they also said that they are doing their jobs in an appropriate manner and hold others responsible for this declining professionalism. In this regard, they pointed out various reasons for this decline. According to them, there is no proper mechanism of accountability to monitor doctors'

performance. Moreover, they blame senior doctors because they always criticise their juniors and disrespect them. They are also not satisfied with their supporting paramedical staff. To provide better healthcare, it is necessary to train doctors in the skills that will make them successful professionals.

One needs to consider that professionalism was investigated as one competency based training of undergraduate medical students, whereas other competencies have not been included. Furthermore, the qualitative approach allows further insights but not an representative overview, although the large sample size.

Conclusion

Any act of malpractice damages public trust in the medical profession and affects the quality of the physician-patient relationship. The new values of medical professionalism and worth of the patient as a consumer should be emphasised and considered to a greater extent in the training of medical students. Patient-centred healthcare service delivery refers to an increased concern for patient satisfaction, health advocacy and health awareness among patients. Thus, efforts should be directed towards minimising the substantial inequalities among health-service providers and seekers, in order to empower patients in Pakistan.

Declarations

Ethics approval and consent to participate

An ethical waiver was obtained from the Institutional Review Board of International Islamic University, Islamabad. All study participants provided written informed consent to participate.

Consent for publication

Not applicable

Availability of data and materials

Pseudonymized transcripts are available upon reasonable request.

Competing interests

The authors declare that they have no competing interests. FF serves as Associate Editor for BMC Public Health.

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The study received no funding.

Authors' contributions

AJ designed and conceived the study. AJ performed the literature review and developed the interview guide. AJ and QKM collected and analyzed data. AJ, QKM and FF wrote the paper. All authors read and approved the final version of the manuscript.

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