

COMMUNITY EXPECTATIONS ABOUT THE ATTRIBUTES OF A PROFESSIONAL DOCTOR

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ABSTRACT

BACKGROUND The training in professionalism is an integral part of the curriculum in both undergraduate and post-graduate medical education. However, the Pakistan Medical and Dental Council (PM&DC) has not explicitly implemented it in the undergraduate medical training.

AIM The aim of this study is to explore community expectations about the attributes of medical doctors.

METHODS This is a qualitative, ethnographic research involving 40 participants from two districts of Khyber Pakhtunkhwa province of Pakistan, who underwent four focus group interviews. The data recovered was transcribed, and 22 codes were identified. The codes were collected under 16 categories that were finally organized under five themes named, knowledge, psychomotor skills, attitudes, professionalism, and ethics.

RESULTS Most of the study participants emphasized on the development of appropriate attitudes, professionalism, and ethics. It was found that no time was allocated to the formal and explicit teaching and assessment of professionalism, development of attitudes or ethical values in PM&DC syllabus.

CONCLUSION The study concluded that our local community emphasizes more on the importance of attitudes and professionalism as compared to the knowledge and skills of medical doctors in contrast to the Pakistan Medical and Dental Council syllabus. The study recommends a curricular reform in undergraduate medical training in Pakistan for including professionalism training and its assessment.

KEY WORDS Professionalism, Attitudes, Pakistan Medical and Dental Council (PM&DC), Focus group interview (FGI)

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INTRODUCTION

An essential aspect of medical training emphasizes the development of appropriate attitudes towards medical professionalism in students. These attitudes have an impact over future practices and affect doctors' relationship with their patients and ultimately the health outcome of the society they serve.¹ Traditionally, knowledge, skills and attitudes are the basic domains that form the attributes of a doctor. In contemporary curricula, ethics and

professionalism have also been incorporated.² The main stakeholders in such programmes are the students, teachers, policy makers and most importantly, the community they serve. This stresses on the need analysis studies to identify expectations of community about the behavior of health professionals.

Medical professionalism forms the basis of the contract between doctors and the society they serve.³ The importance of teaching medical professionalism has been emphasized

worldwide.⁴ Medical schools have begun to emphasize the teaching of such qualities.⁵ The different international accrediting bodies have included attitudes and professionalism apart from knowledge and skills as attributes of doctors.⁶⁻⁹

The teaching hospital environments in Pakistan are mostly focused on treatments, both pharmacological and interventional and barely on inculcating the professional values, which are needed for the students, namely altruism and respect. There appears to be no formal environment of respect for patients and their families.¹⁰ Moreover, it has been observed that even if patients are treated properly and cured in our hospitals, they are not satisfied. This prompted us to identify the perceptions and expectations from our community about the attributes of

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medical professionals so that it can be addressed to the policy makers and other related authorities to act accordingly.

The aim of this study is to answer two questions. Firstly, it will identify the expectations of local communities regarding the attributes of doctors. Secondly, it will identify the time allocated in PM&DC undergraduate medical education and training syllabus for teaching attitudes, professionalism, ethics and research and to compare its alignment with the community needs.

METHODS

This qualitative ethnographic research was conducted in two districts of Khyber Pakhtunkhwa province of Pakistan, namely Swabi and Peshawar. Twenty participants from each district were included. Participants were selected purposively by selecting from patients and their relatives as they had better exposure to the health services and doctors. Representatives from the community were also included. Participants with age less than 18 years were excluded. Similarly, relatives with no past exposure to a hospital setting were also excluded. These participants were divided into two groups based on their educational status, twenty participants with educational qualification of Grade 10 and above and 20 below Grade 10 (Table-1). The division of participants according to educational status was done to find out the difference in ideas and views between educated and less educated individuals (Grade 10 and above, and less than Grade 10).

We developed six open-ended questions for data collection. The questions were pilot tested in Lady Reading Hospital, Peshawar with a group of 5 doctors in a Focus group interview (FGI). These questions were re-visited after the interview and were further elaborated, and finalized. The questions were written in English, but were translated in local language during the interview.

Different venues were used for different FGIs according to the localities. The participants from district Swabi were interviewed in Swabi, and two Focus group interviews were conducted in Peshawar. The duration of FGIs ranged from 40 minute to 75 minutes. Participants were between ages of 18-55 years in different interviews. All of the participants were interviewed in local language i.e. Pashto. The two sources of the data were audiotapes of the interviews and field notes. The data was transcribed afterwards in English language.

During data analysis, the qualities described were colour coded. Field notes were also included in the data. Different qualities described by the participants were given different codes. The codes were then classified into categories. The categories were later grouped under five themes, i.e., cognition, psychomotor skills, attitudes, ethics and professionalism.

The credibility of the findings was established using triangulation techniques. The findings were limited to the two districts of Khyber Pakhtunkhwa. Therefore, claims cannot be made for the transferability of the data beyond these two districts

as there may be some local variations due to changes in language and expression of thoughts due to cultural diversity in the country.

The PM&DC curricular document for the MBBS course, which is currently followed in the medical schools in Pakistan, was analysed by both the researchers for the learning outcomes related to professionalism.¹¹

RESULTS

A total of 22 codes were identified, shown in Table 2. The codes were then organized under 16 categories. The categories were later classified into 5 themes named, knowledge, skills, attitudes, professionalism and ethics, shown in Figure 1. The most important codes identified belonged to the morality, followed by way of talking, duty, timely action, politeness, and respect in descending order of frequency. The most frequently used codes belonged to attitudes, followed by professionalism, cognition, ethics and skills in descending order of frequency.

Exploration of PM&DC syllabus: The following observations were made after searching the PM&DC syllabus:¹¹

Mostly, the time allocation is related to the knowledge and skills components of different subjects.

There is no explicit time allocation for professionalism teaching. Although, there may be informal teaching during hospital visits to individual units.

Some of the components of bio-ethics are taught in Forensic medicine. However, there is no evidence of formal formative or summative assessment for it.

Behavioral sciences teaching is said to be somewhat related to the teaching of some components of professionalism. However, the mode of delivery is not clearly stated, and it has not been given weight in assessment.

The basic understandings about these topics have been introduced in the recently updated PM&DC

TABLE 1: DISTRIBUTION OF PARTICIPANTS

S. No	Swabi		Peshawar	
	A*-1	B*-1	A*-2	B*-2
	8	10	14	8
Total	18		22	
40 participants				

*Alphabets have been given to different groups according to educational background [A=grade 10 and above, and B=below grade 10].

TABLE 2: DISTRIBUTION OF QUALITIES DESCRIBED BY THE PARTICIPANTS IN EACH INTERVIEWS, THEIR FREQUENCIES (IN DESCENDING ORDER) AND CODES GIVEN TO EACH QUALITY

S. No	Words used	Individual interviews				Number of times used	Codes given
		A1	B1	A2	B2		
1	Morality (Akhlaq in Urdu)	4	10	10	8	32	Ak
2	Communication skills (way of talking) how to speak to patients and relatives)	4	7	8	7	26	CS (W/T)
3	Duty (performing proper duty)	7	6	3	5	21	D
4	Should not make the patient wait for longer times and should act timely	4	6	6	1	17	WX
5	Greets the patients, and should be lenient and polite	2	3	3	6	14	Gr
6	Patient respect	3	2	5	3	13	R
7	Prescription of high quality and appropriate drugs	0	5	3	4	12	PD
8	Should act in time without delay	3	5	3	1	12	AxD
9	Helpful to patients / guides patients	2	3	2	3	10	H.G
10	Empathy, feeling patients as his own close relative	4	2	0	4	10	M
11	Appropriate explanation about the disease Of the patients	2	2	2	2	8	DE
12	Good behavior	2	5	1	0	8	GB
13	Trained/specialized/expert	2	1	1	1	5	Tr
14	Patient guidance and explanation	1	2	1	0	4	PG
15	Proper and detailed history	1	2	1	0	4	Hx
16	Doctor should be clean and virtuous	1	0	1	1	3	C.V
17	Examines the patient properly	0	1	1	1	3	Ex
18	Equality (between poor and rich, and hospital OPD and private clinic)	2	1	0	0	3	E
19	Proper patient referral	1	1	1	0	3	PR
20	Treat patient properly	1	0	1	1	3	Tx
21	Knowledge and understanding	0	0	2	0	2	Kn
22	Diagnose the patient properly	0	0	1	0	1	Dx

curriculum in 2011. However, it has neither been implemented by the medical colleges in the country nor there is any inclusion of these topics in assessment.¹²

DISCUSSION

The most important attribute mentioned by the participants was morality that literally means good behavior and verbal communication with others. The study participants' views were influenced by their religious values. They mentioned that one of the most important attribute in the Islamic religion is 'Akhlaq' (morality).

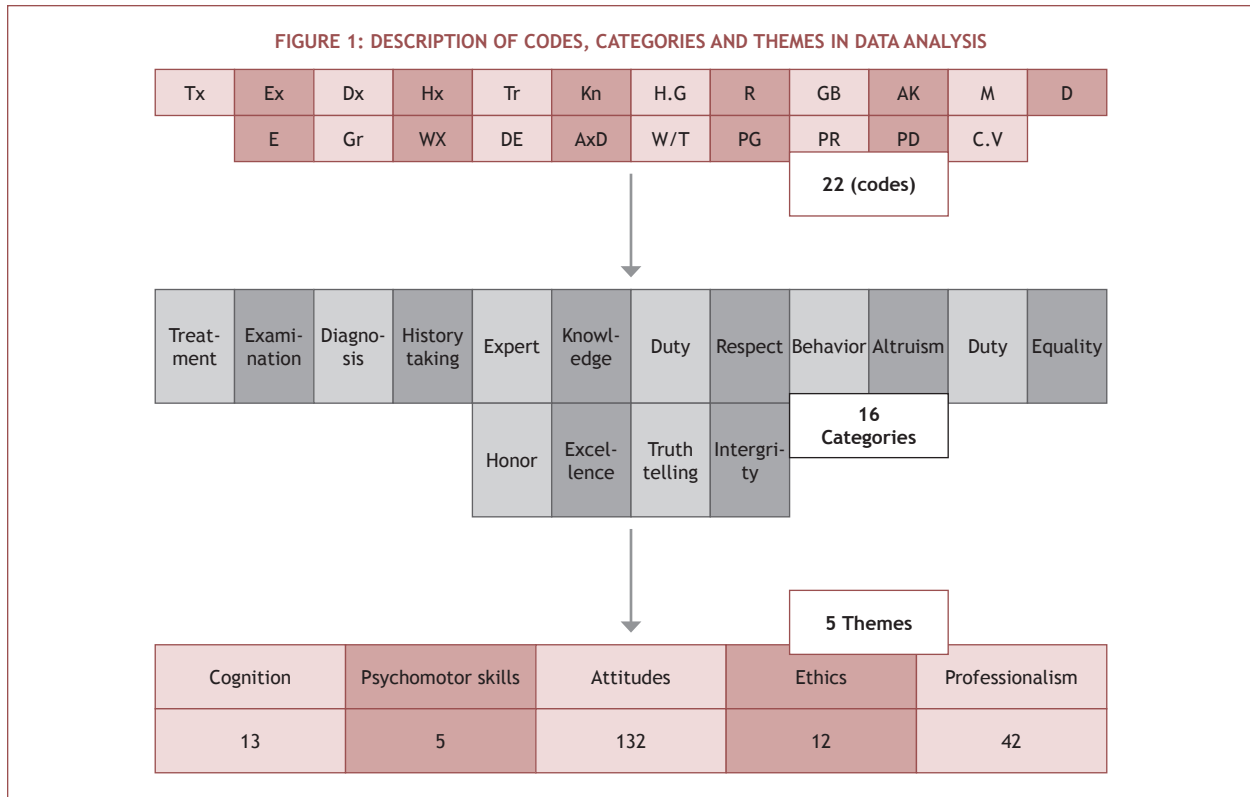
The participants stressed on communication skills as the second important attribute for a professional doctor. Many medical schools inter-

nationally have incorporated formal training and assessment of communication skills using videos, role plays, group discussions, lectures and true and simulated patients.^{5, 13, 14} In contrary to the international standards, there is no significant formal communication skill training in the PM&DC curriculum.¹¹ The need for training in communication skills is important because of the non-equal positions in doctor-patient relationship. The sharing of sensitive information between doctors and patients is still through interpersonal communication despite the technological advancement in health sciences.

The other qualities described by the participants of the study were related to duty, respect, honour, and truth telling, which are components

of professionalism and attitudes. A small number of participants who emphasized over the importance of knowledge and skills were those who were educated. The less educated group almost exclusively emphasized over the attitudes. This is because educated people might consider the significance of knowledge and skills as equally important as attitudes and professionalism. These findings are in consistence with previous studies.^{15, 16} However, there may be difference in opinions due to other demographic variations, not considered in this study.¹⁷

The perceptions of participants found in this study were in contrary to the existing PM&DC curriculum. The issues, such as social accountability and patient safety that are



important for patients and incorporated in the western curricula, have not been given due importance by the PM&DC.¹⁸

The analysis of the PM&DC syllabus showed that no time was allocated to the formal and explicit teaching and assessment of professionalism, development of attitudes or ethical values.¹¹ All the hours were allocated to teaching the major and minor basic sciences and clinical subjects. More so, the formal training in attitudes and communications skills has not been mentioned in clinical training starting from 3rd year and beyond. Similarly, there is no formal assessment of attitudes and professionalism in both formative and summative assessments. This may be one reason that leads to the exhibition of improper attitudes by doctors in clinical practice.

The PM&DC syllabus analysis also showed two more points. First, the assumption that behavioural sciences cover the teaching of professionalism, attitudes and ethics is not totally true. The contents taught

in behavioural sciences covers the topics of human psychology and a chapter on communication skills. Moreover, the communication skill training is done in the preclinical years where there is no contact of students with the patients, which apparently has no or less impact on the overall professional behaviours of students in later years. Second, it is mentioned in the footprints of table of time allocation for different subjects in PM&DC curriculum, that bioethics will be taught in the Forensic medicine. In reality, there is no formal training and assessment of bioethics in the Forensic medicine. This may be partly because of lack of faculty training and implementation issue on part of the individual medical schools.

CONCLUSION

The participants in this research mostly emphasized on the attitudes, rather than over the knowledge and skill of medical professionals. The main emphasis of them was on communication skills, humane na-

ture, respect and patient safety. The study highlighted the incorporation of teaching and assessment of ethics and professionalism in the PM&DC curriculum. This study will prompt further research on the topic and may stimulate curricular reforms in undergraduate medical training in Pakistan. Similar studies may also stimulate the process of faculty development in professionalism training and its assessment in both undergraduate and postgraduate medical education in Pakistan.

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NOTES ON CONTRIBUTORS

The study was part of FA Masters in Health Professions Education. UM supervised the dissertation, and was involved in every part of the analysis, idea's development, and write-up.

CONFLICT OF INTEREST

Authors declare no conflict of interest.

ETHICS APPROVAL

The approval/permission was obtained from Khyber Medical University Research and Ethics Board.

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