Understanding the stakeholders' perspectives on professionalism in healthcare: a cross-cultural analysis

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Abstract

The term 'medical professionalism' lacks a universally agreed definition. The purpose of this research was to understand the meanings made by a range of stakeholders - doctors, patients, health profession students, healthcare policymakers, nurses and other allied healthcare professionals – of their lived experiences and perceptions of medical professionalism, across the demographically, economically and socio-culturally divergent province of Punjab in Pakistan.

The focus was on how different individuals involved within healthcare delivery would make sense of the term depending on their lived experiences and socio-cultural standing within the community, the prevalent culture, the context and setting and other less understood factors. It seemed possible that comparisons of this understanding between the Pakistani study group and other parts of the world (as represented in the literature) would help in developing a more nuanced and useful definition of medical professionalism.

The following three questions guided the research:

1) What are the perceptions of doctors, nurses, students, administrators and policymakers in Punjab, Pakistan, regarding medical professionalism?

2) How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?

3) How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

The study design was qualitative and a case study approach was employed. 530 individuals took part in thirty-eight focus group discussions, with 8-15

participants in each group, in various settings across the province of Punjab, comprising doctors, health professional students, patients, policy-makers, nurses and other allied health professionals. Thematic analysis was undertaken of the transcribed data.

Four distinct superordinate themes were identified: VALUES-DRIVEN, ADEPT, POTENT LEADER and SUPPORTED. These four themes were common to all stakeholder groups. All resonate closely with themes in the international literature, although the theme SUPPORTED appears to draw together issues in a way unique to the Pakistan context. There were greater variations in findings from amongst the stakeholder groups at the subordinate themes and further lower levels of thematic analysis. Related to their different contexts and experiences, different stakeholder groups emphasised the following aspects: professional identity; the need for training; the support for professionalism (or lack of it) within their working environment; the link between religious beliefs and professional behaviour; cultural expectations of the doctor-petient relationship.

It is concluded that understanding of medical professionalism vaies among stakeholders and depends on context, culture, environment and many other factors identified in this research. Professionalism, thus, is not a static, stable construct and it is not possible to confine it within a single generic definition on account of its cultural and situational dependency. It is a dynamic and constantly evolving phenomenon which cannot be represented by the type of linear, unidimensional model typically presented by the majority of researchers.

This research study lays the foundation for further research in this area, especially in trying to understand how best to promote medical professionalism so as to ensure that healthcare encounters are meaningful and satisfactory for all concerned.

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Chapter 1 Introduction

In the present era, the growing ability of health care systems to diagnose and treat diseases, together with changes in financing and healthcare delivery standards, have pointed out many ethical and professional issues for physicians. The training of devoted professionals with specialized skills is needed for the development of modern medicine and technology and these trained professionals are expected to follow the codes of professionalism. Conflicts of interests and medical errors are being discussed on professional platforms to meet the challenges of the modern epoch; in response to which there are growing demands for making positive changes in medical curricula. These in turn set grounds for professional accountability. For the betterment of healthcare systems and managed care, people are now thinking to bring about more positive changes in the attitude and behaviour of physicians towards their patients and staff as well as the understanding of their own roles to fulfill their professional responsibilities.

My interest in the field of medical professionalism is longstanding. For as far as I can remember, I was distressed to note the challenge that existed between the values taught and the ones practiced in school, in the society and even in our homes in Pakistan. This contrast grew stronger as I entered medical school and watched with dismay how the environment and culture of practice of medicine differed from that taught and idealized. Having worked in Pakistan as well as in the United Kingdom, I identified stark differences and to my surprise similarities in both the positives and negatives of the practice of medical professionalism in these two completely different settings and environments. My interest in professionalism grew further when as a student of health professions education I was able to research in this area as part of my studies: it also influenced my choice to switch career on my return to Pakistan in 2006 from a general and breast cancer surgeon to a full-time dedicated medical educationist. This thesis is part of that journey; a journey to seek out the nature of this

phenomenon that has perplexed educationists and practitioners alike for generations and perhaps will continue to do so for many more years to come.

The evolution of medical professionalism is not at the same stage in all institutions and countries. Some are more progressive in this field while others are less so (Shultz, 2011). In the 90's, the American Board of Internal Medicine (ABIM) tried to formulate their conceptual understanding of medical professionalism with the intention of merging core views into a generally standardized list (ABIM Foundation, 2002). This list of core competencies of professionalism in the medical field has been valued in several countries of the world (Parks & O'Malley, 2016). According to ABIM, medical professionalism consists of these sets of behaviours:

- The physician-patient relationship, that is, the physician's responsibility to serve as the patient's spokesman which has been identified as the bedrock of medical professionalism;
- Physicians' social responsibility, that is, their responsibility to social justice and keeping social wellbeing foremost;
- Physicians' humanistic values, that is, candour and reliability, kindness and care, unselfishness and sympathy, revere for masses with credibility;
- Proper checks and balances implemented by physicians for themselves and for their fellows. They should set and impose standards of practice and should not defend futile or inappropriate practice in order to save incompetent physicians;
- An enduring dedication to perfection. Proficiency is actually an imperative professional feature. Professions are dependent on intellectual toil, deep knowledge and skills;

- A demonstrated dedication to erudition while focusing on research towards advancement in respective fields; if dedication to perfection has an inner interaction then a dedication to scholarship has an outer interaction.

Brennan, Price, Archer and Brett (2019) argued that medical professionalism is influenced by many factors and issues at the same time. According to Bourgeois-Law, Teunissen and Regehr (2018) these factors and issues may arise within the medical profession itself or from the environment in which physicians must practice. Marcum (2019) noted the general perception that the medical profession has become less humane now than it once was. This decline is believed by Chee (1999) to be mainly due to the decline in professionalism in the behavior of fresh graduates, as they are not properly taught professionalism and self-regulation in their medical curricula.

Over the course of a few years, the European Federation of Internal Medicine, the American College of Physicians-American Society of Internal Medicine, the American Board of Internal Medicine (ABIM), the American College of Surgeons (ACS), the American Medical Association (AMA), the Association of American Medical Colleges, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, the Royal College of Physicians of London and other professional organizations and individuals have outlined definitions and proclamations on professionalism (Shukr, 2014). These edicts jointly compose a remarkable catalogue of virtues and create many definitions of professionalism.

One of the more comprehensive definitions of 'professionalism' comes from the Canadian Medical Association:

> "The term professionalism is used to describe those skills, attitudes and behaviors which we have come to expect from individuals during the practice of their profession and includes concepts such as maintenance of competence, ethical behavior, integrity, honesty, altruism, service to others, adherence to professional codes, justice, respect for others, self-regulation, etc." (Jamal, 2009)

Aguilar, Stupans, Scutter and King (2013) claimed that professionalism involves practitioners applying the principles of their profession and displaying vital professional behaviours and attitudes. Professionalism development depends on learning, and learning depends on a number of factors. The learning environment is an important facet of a health care provider's professional development which must be considered in both undergraduate and postgraduate medical education. Everything happening in a classroom, in a department or in an institute contributes to this environment or the professionalism culture of that institute. The impact of this culture is something that is well recognized and accepted because of its real influence over students' achievements, satisfaction and success. Badsar, Taramsari, Hoseinpour and Jahromi (2012) are of the opinion that this educational environment and institutional culture can be measured, but this may not always lead to quite exact measurements that could qualify for remedial actions.

According to a Lancet review in 2000 (Cruess, Cruess & Johnston, 2000), it is crucial to teach professionalism in medical institutions and serious research is required in this area. Passi, Doug, Peile and Johnson (2010) summarised on the basis of this that we could develop high standards and recommendations for developing good environments in medical institutions that promote professionalism. Palis and Altszul (2019) note that research and literature in the field of medical professionalism has been growing rapidly over the last couple of decades which suggests that teaching and assessing professionalism in medical institutes is seen as a high priority.

Gruen, Pearson & Brennan (2004) note that professional organizations are being set up to defend the rights of members, regulate and discipline practitioners, regulate training, and promote scientific research and exchange. Kasule (2013) maintains that professionalism should be taught actively as structured curriculum courses or passively as apprenticeship under good role models. However, Mann, Ruedy, Millar and Andreou (2005) argued that

despite repeated claims about their importance, the characteristics and the behaviours of medical students in relation to the development of professionalism have proved exigent both to define and to measure.

Another factor is the extent to which a healthcare system within a society is established according to the traditional values of that society. The doctor has to practise within whatever system exists, a factor which is obviously outside the direct control of the medical profession.

Arnold and Stern (2006) note that the pursuit of professionalism encourages all members to embrace the traditions of the profession and to be as "professional" as they can in their particular context and situation. Goldberg (2008) categorizes professionalism as the insular, culturally-determined practices of a particular professional group that may or may not conform to set expectations. 'Professionalism', thus, is a socially constructed local phenomenon. Apart from the taught curricula, the hidden curricula, informal curricula and meta-curricula play their own immersive roles in the structuring of the professionalism framework individually and collectively (Goldberg, 2008). Christianson, McBride, Vari, Olson and Wilson (2007) recognized that these terms describe a culture of medical education with unwritten rules that influence attitudes and behaviors during training and later during medical practice. However, hospital culture is by no means entirely hostile, and many trainees graduate from it having cultivated positive and caring professional identities (Coulehan, 2005).

Cultural drivers or environmental factors surely affect the behaviour of the members of that culture. These include both the general public and professionals. In a country or a region, there may be one perception or practice of professionalism while in some other region there may be some different understanding and perceptions. This may lead to variations in the practice of professionalism in different environments. Now if we see medical professionalism

from a cross-cultural perspective, there are somewhat differing viewpoints and varying degrees of difficulty in its implementation in Western and non-Western cultures.

Looking below the surface of intricate problems involving cultural, social and attitudinal factors, signs of ambivalence or even conflict in attitudes were discovered, stemming from personal doubts and insecurities or contextual fears and constraints in a study by Deedar-Ali-Khawaja and Khan (2010). These attitudinal thresholds should be overcome by aiding and supporting these young graduates as much as possible (Moekotte, Brand-Gruwel, Ritzen & Simons, 2015).The interpersonal relations, learning, peer pressure, and peer review provided by collegial processes of reflection ensure that this will lead to a better professional culture. The integration of education and practice, combined with linkages to community settings, enables the organisations to conduct more of education and practice in community-based settings, to place greater emphasis on primary and ambulatory care and to make education and practice more sensitive to patients' social and cultural situations (Frankford, Patterson & Konrad, 2000). The question remains: will that improve professional conduct by health care providers?

In the present study, the researcher desired to compare the cultural drivers which affect the learning, practice and perceptions of medical professionalism in Pakistan compared with more developed countries. 'Cultural drivers' here mean the customs, traditions, norms, backgrounds and behaviours of the members of a culture. Das, Woskie, Rajbhandari, Abbasi, & Jha (2018) argue that the culture of Eastern countries is different from that of Western countries and there are many differences in their lifestyles and hence how they behave in different fields of life. Every country or area of the world has different beliefs, norms and ways of life which are the major factors that define the path towards the professionalism future for their citizens. These norms and ways collectively make up their culture. Hence, the

culture of a place or a country cannot be ignored while talking about practices and perceptions regarding any act or knowledge.

People behave according to their own customs and traditions. For instance, if in a country where there is a well-developed 'culture of research' in the field of education then we do not need much hard work to convince academics or students to initiate any specific research work; but on the contrary, if in a country there are fewer resources and less inclination towards research then we have to do much more work to convince their students to carry out any research work (Chakravarthy *et al*., 2011).

Nowadays, many institutions are focusing on professionalism, making it a key element of educational programs as well as an integral part of the medical school culture (Arnold *et al*., 2007). In a study done by Monrouxe, Rees and Hu (2011) in the United States of America, nearly all medical schools reported that they had made some changes in their medical syllabi but still they did not have valid and reliable means for teaching and assessing professionalism to their students.

Monrouxe *et al*. (2011) suggest that among the existing definitions of professionalism some are easily understandable by the readers and researchers while some need detailed explanations regarding their principles, aspects and dimensions. The authors conclude that before teaching and assessing professionalism, the need is to develop a concise definition of professionalism. They argue that this could be done by medical educators, medical professionals and other stakeholders. Some of these have the view point that this is a simple task as the definition can be extracted from policy documents and dictionaries and can be implemented accordingly; while others think that the definitions in this field cannot be adopted and implemented as they are, since there may arise some conflicts in their explanations due to various incomplete and indistinct meanings (Das *et al*., 2018). Hence, in

this regard, proper definitions may be developed either by mixing different existing definitions or generating new ones.

Now is the time to bring positive changes in medical curricula to provide a good understanding of and training in professionalism to our medical graduates. No longer can we continue to view a curriculum as a linear road trip, singular and unidimensional.

1.1. The context of this study

Since independence in 1947, Pakistan has produced many competent and well-qualified professionals in the area of medicine despite challenges (Talati & Pappas, 2006). The roots of the present system of education are in the colonial era and there has been slow progress in the development of the medical education sector in the country. Naqvi (1997) noted that a number of challenges in this regard were associated with a lack of a proper facilitating attitude on the part of policy makers. This in his opinion needed to be sorted out in order for any progress in this sector to materialize.

Many issues and shortcomings regarding medical education in Pakistan have been identified (Naqvi, 1997; Anjum, 2018). Table 1.1 summarises the major issues at present. Anjum (2018) states that though there is growth in the number of medical colleges the desired impact on healthcare indices has not been achieved. This has also raised a question regarding the quality of the medical education in Pakistan. Anjum states that there exists a gap in the provision of education and the growing number of medical institutions in Pakistan. Multiple aspects have created this lacuna including inequality in the distribution of resources, a poor assessment system, outdated curricula, neglected research and untrained faculty (Anjum, 2018).

Table 1.1 Summary of issues highlighted by Naqvi (1997) and Anjum (2018)

- Despite having approximately 169 medical colleges in Pakistan, the ratio of doctors per head of population is quite low, roughly 1:1500.
- Problems exist in the distribution, equity and access to healthcare facilities despite the increases in medical colleges.
- The medical curriculum does not cater to the health needs of the population due to lack of periodical revision.
- Medical education is directed towards passing exams due to the lack of emphasis on clinical training and failure to integrate basic and clinical sciences.
- Due to the growth of private medical colleges compared to the government sector – 108 medical or dental colleges compared to 61 - the standard of medical education has been diluted.
- Innovative curricula, faculty development programmes and better assessment methods are required for quality health care education.

The general picture is still bleak even though there have been discussions, changes in policy, recommendations and interventions (Siddiqui & Shaikh, 2014). It is interesting to note that very little literature is available on the topic and that which exists continues to identify the same set of issues and challenges over decades that seem not to have been managed over time (Naqvi, 1997; Anjum, 2018). It appears that all efforts to meet the demands of an expanding population are unable to keep up pace with its rapid increase. Population growth rate rose steadily from 2.6% per annum in the early 1960s to a high of about 3.5% in the late 1980s (Feeney & Alam, 2003) and is currently estimated at 210.13 million (Ahmed & Ahmad, 2016). A recent study by Nyoni (2019) estimates that the population will continue to rise sharply over the next three decades to 324 million by 2050.

The healthcare delivery system is divided into primary healthcare units (rural health centres and basic health units), secondary (tehsil headquarter and district headquarter) hospitals and tertiary hospitals (teaching hospitals which are mostly located in major cities). According to the Pakistan Economic Survey 2018-19, there are 1,279 public hospitals, 5,527 basic health units, 686 rural health centres and 5,617 dispensaries. The military, the railways

and airlines also provide healthcare services to their employees and families (Nizar & Chagani, 2016; Latif & Wajid, 2018).

There are 220,829 registered doctors, 22,595 registered dentists and 108,474 registered nurses. There are a total of 73,650 private healthcare institutions, 8 tertiary care hospitals, 692 small and medium sized hospitals with the capacity of 20,000 beds (Fulu *et al*., 2009). Table 1.2 depicts the key statistics of Pakistan related to the healthcare industry.

According to a report by the World Health Organization (WHO, 2016) the density of physicians, nurses and midwives is below the world averages. This suggests an excessive workload with unfavorable effects on the quality of healthcare leading to poor patient outcomes (Lang, Hodge, Olson, Romano & Kravitz, 2004: Khalid & Abbasi, 2018). Habib and Khan (2017) stated that there was an acute shortage of in-patient beds: also the delivery of babies was being carried out on floors.

Table 1.2. Healthcare industry statistics of Pakistan

Total population (2016)	**193,203,000**
Gross national income per capita (USD, 2018)	**1580**
Gross domestic product (Billion USD, 2019)	163
Total expenditure on health as % of GDP (2014)	**2.6**
Hospital Beds per 10,000 Population (2014)	20
Density of physicians per 10,000 population	7.8%
Density of nurses and midwives per 10,000 population	3.8%

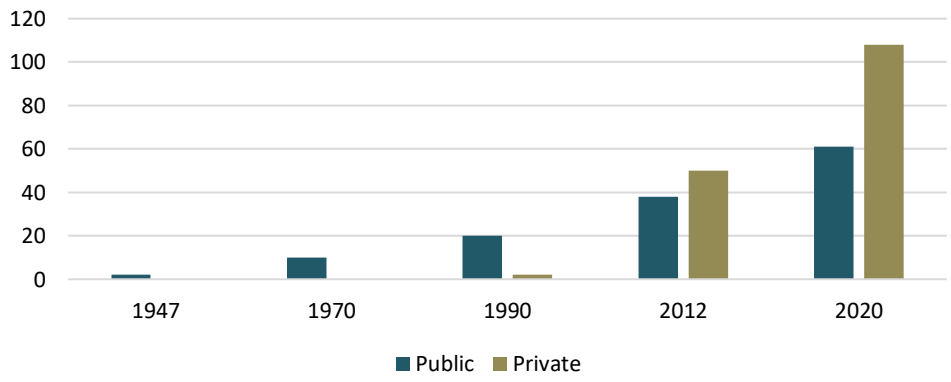
Source. Pakistan Bureau of Statistics

The growth of the healthcare workforce and medical colleges has been a priority in Pakistan over the past 68 years (Talati & Pappas 2006; Nishtar 2010; Abdullah, Mukhtar, Wazir, Gilani, Gorar & Shaikh, 2014). The Pakistan Medical and Dental Council (PMDC), the regulatory authority for the monitoring and evaluation of medical colleges, was formed in 1962 and the College of Physicians and Surgeons Pakistan (CPSP), a formal postgraduate

training institute, was established in 1962 (Rathore, 2013). There were only two medical colleges at the time of creation of Pakistan in 1947: according to the Pakistan Medical & Dental Council (http://pmdc.org.pk/), there are currently 45 medical and 16 dental colleges in the public sector and 68 medical and 40 dental colleges in the private sector.

Provision was dominated by the public sector till 1990, when the corporate sector was allowed to establish private medical colleges and the balance started tilting towards the private sector (Latif & Wajid, 2018). As Table 1.3 shows, there has been a rapid increase in private medical colleges over the last two decades (Bokhari, 2019). He further adds that the system of medical education and healthcare delivery is affected by maldistribution of resources, lack of updated curriculum, flaws in assessment and deficiency of appropriate faculty development programmes.

Table 1.3: Expansion of Medical Colleges Since 1947



Also, the direct involvement of private and commercial interests in the higher education has made it a profit industry, as is the case in India (Kapur & Mehta 2004; Narayana, 2004). According to Naqvi (1997) and Anjum (2018), other prominent issues include flaws in admission procedures - students are admitted to private medical colleges on lower grades – and a lack of transparency in capitation fees across different medical colleges. Anjum (2018) claims that privatization leads to unhealthy competition, poor infrastructure,

and shortage of teaching faculty, all of which engender incompetent graduates with poor practical skills.

The healthcare system is mainly governed by the provincial authorities. However, the federal government caters to the needs for health laws and policy-making at the national level apart from generating funds from abroad, organizing public health facilities and creating awareness through educational programs (Ghaffar & Qureshi, 2013). Efforts have been made by the government to develop medical colleges in different regions and to admit students based on the criteria of a particular province or region. However, these policies have still not been implemented (Siddiqui & Shaikh, 2014). Table 1.4 depicts the distribution of medical colleges and undergraduate places in Pakistan. Despite the increase in private medical institutions, these institutions with their location in major cities specifically ignore the demand for medical institutions in the less developed areas (Abdullah *et al*., 2014).

Table 1.4. Distribution of Registered Medical Colleges and Undergraduate Medical Places in Pakistan

Number of Medical Colleges

Province	**Total**	**Public**	**Private**	**Medical Seats**
Punjab & Federal	62	19	43	7800
Sindh	26	11	15	3550
Khyber Pakhtunkhwa	20	10	10	1750
Balochistan	2	1	1	200
AJK	4	3	1	400
Total	**114**	**44**	**70**	**13,700**

Source: Bokhari (2019) & Pakistan Medical and Dental Council (2018)

The admission capacity of all these colleges is approximately 20,000 per year for MBBS, of which about 4000 are trained each year by the government medical colleges, and 5000 per year for BDS (http://pmdc.org.pk/). Every year out of a total 85000 doctors in Pakistan around 2000 doctors die, 500 go abroad for practice and around 200 female doctors stop practising (Khan, 2016). In order to promote social advancement and improve healthcare standards, it is crucial to assess these shortcomings and plan strategies accordingly. The dire need cannot be denied for innovative strategies and policies to bring reforms across the entire medical system (Latif & Wajid, 2018).

To accredit, regulate and ensure the quality of medical education, the PMDC is the sole authority. The initial set of regulations were crafted in 1962 and the latest were published in 2018 (PMDC, 2018): they are imposed as legal and mandatory requirements by the government. These regulations are intended to maintain strict standards in terms of guidelines, characteristics and criteria to achieve desired quality levels (PMDC, 2018). In the academic year 2015-2016, 17 public and private medical colleges were banned from admitting students for being deficient in faculty and other facilities (Latif & Wajid, 2018).

The Pakistan Medical and Dental Council has recommended that: “a physician shall always maintain the highest standards of professional conduct…being in conformity with principles of honesty, and justice” (PMDC 2009 p.11) and has encouraged medical colleges to include medical ethics in their taught curriculum.

Recent regulations focus on the infrastructure evaluation and ‘head count’ in medical colleges rather than measuring and ensuring educational processes and outcomes. An inspection process is lacking that certifies how the existence of physical facilities and faculty leads to quality outcomes (Javaid, 2017). The lack of ambition in accreditation standards is facilitating a growing number of medical colleges but the quality of medical education and the outcomes are affected (Goswami & Sohai, 2015). Sethi and Javaid (2017) stated that the

required reforms included reforms to the curriculum to base medical education practice on something other than theoretical training. They point to a dire need for PMDC to develop robust standards that are reliable, valid, measurable, acceptable to and compatible with the changing local and global scenario. Apart from developing these new standards, there is also the need to redesign and review the accreditation system and reinforce its capacity to ensure that the existing number of medical and dental colleges comply with the new standards (Sethi & Javaid 2017).

Medicine is the most sought-after profession in Pakistan. Admission to medical college specifically in the public sector is highly competitive: here, the admission policy provides equal opportunities to students from all financial and social strata (Sood & Adkoli, 2000). The selection procedure includes the marks scored at intermediate/'A' levels and Matric/'O' levels in addition to an entrance exam conducted across Pakistan. Very few or no medical colleges use interviews as a basis for admission.

There are challenges to the effectiveness of these entrance tests. They ignore aptitude, analyzing capabilities, communication skills and humanitarian qualities. Medical educators in the field of medical education have already questioned the validity of selecting the candidates on the basis of multiple-choice questions (Solanki & Kashyup, 2014). Entrance exams minimize the significance of clinical skills at postgraduate level and simply emphasize knowledge acquisition. It has been proposed that to maintain quality in the admission system is to a single entrance exam should be conducted across Pakistan which includes personality assessments (Huda, 2001; Solanki & Kashyup, 2014).

Medical curricula in Pakistan suffer from traditional didactic teaching methods, absence of integration, limited research activities and little emphasis on the affective domain (Khalid & Abbassi, 2018). Smits, Verbeek & Buisonjé (2002) suggest that to transform the curricula, it is crucial to bring about vertical and horizontal integration together with an

evidence-based approach that emphasizes the clinical and basic sciences equally, using problem-based methodologies to promote deeper learning and critical thinking and a competency-based approach for the acquisition of skills. Smits, Buisonjé, Verbeek, van Dijk, Metz and Ten Cate (2003) noted that a shift towards a community-based curriculum is required for improving community service and care. Although PMDC has placed more emphasis on a more integrated teaching framework and skill-based learning, changes have still not come.

Khan, Biggs, Tabasum and Iqbal (2012) argue that if the assessment system fails to judge the potential and genuine capabilities of a student, then its purpose is lost. Theory examinations in Pakistan mostly follow a summative questioning method that is devoid of any analytical techniques (Schuwirth & Van der Vleuten, 2011). Assessment mostly lacks feedback that provides students with the opportunity to learn (Ahmed & Tufail, 2016). Moreover, skills assessment is mostly absent.

The growth of any educational system relies on the expertise of teaching faculty (Singh *et al*. 2013). According to Anwar and Humayun (2015), as the number of medical colleges has increased in Pakistan, a shortage of faculty, insufficient faculty development programmes challenges the quality of education. There is faculty evaluation but the absence of a reward system makes the faculty anxious and ill-informed about the latest pedagogic methods. Day, Sammons and Stobart (2007) argue that the quality of medical educators is affected when the eligibility criteria for appointment of faculty are relaxed. Skeff *et al*. (1997) identify a lack of incentives, lack of faculty interest and a shortage of trained faculty as barriers to faculty development.

Finally, Beine, Docquier and Rapoport (2008) pointed to the loss of public money spent on medical education by the Government and manpower due to migration. While they recognized the right of an individual to migrate abroad as a justification for the brain-drain,

where government is spending large amounts of public money on the production of healthcare providers and is then deprived of them this disrupts societal justice. Shaikh, Naqvi, Sheikh, Naqvi and Bandukda (2012) stated that 35,000 US dollars were being spent on medical education, yet Pakistan was still not able to fight avoidable health problems such as diarrheal diseases, malaria, tuberculosis and high levels of perinatal and maternal mortality. Hossain, Shah, Shah and Lateef (2016) concluded that insecurity, low salaries and poor career structure are the primary factors for this medical brain-drain. To reverse this, urgent interventions are required (Astor *et al*., 2005).

1.2 Structure of the thesis and research questions

In chapter 2 a review of the literature related to health professionals' understanding of professionalism is presented followed by the set of methodological choices I have made in chapter 3. Chapter 4 presents the main findings in relation to the research questions 1 & 2, and chapter 5 presents findings in relation to research question 3. Chapter 6 presents discussion and conclusions. It is pertinent to mention that research findings are presented alongside the literature and analysis in order to develop an argument that facilitates understanding of findings and analysis with relevance to literature evidence. The research questions this study seeks to answer are the following:

1. What are the perceptions of doctors, nurses, students, administrators and policymakers in the Punjab, Pakistan, regarding medical professionalism?
2. How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?
3. How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

Chapter 2 Literature Review

2.1. Literature search

In order to explore the cultural drivers affecting the learning, practice and perception of medical professionalism, a scoping review of the literature was undertaken. The database of the University of Liverpool online library was used for this purpose. Search terms used can be found in Appendix I.

The main purpose of carrying out a scoping review of the literature is to identify the nature and extent of the research evidence available on the subject. Scoping reviews are particularly useful in synthesizing research evidence. They are used to label a body of literature with relevance to time, location, source and origin, clarifying working definitions and conceptual boundaries of a topic or field and identifying existing gaps in literature & research (Peters et al., 2015). For this reason a scoping review was considered suitable for this research study.

2.2. Introduction

Much has been written in recent years on professionalism (Kinghorn, McEvoy, Michel & Balboni, 2007; Coulehan, 2005; Dogra, Dogra, Betancourt, Park & Sprague-Martinez, 2009). Birden *et al.* (2014) in a systematic review identified 195 papers whose authors had endeavoured to define medical professionalism. They rated 26 out of these 195 papers as high quality, including these in their narrative synthesis. They pointed out that the world literature presents a considerable difference of opinion as to what defines medical professionalism, and that the literature is full of conceptual overlaps amongst professionalism, humanism and professional and personal development.

Brennan & Monson (2014) noted a rebirth of interest in professionalism in the 1980's when healthcare managing organizations were established which also monitored and reported the impact on healthcare delivery of various factors including professionalism. They commented that in the more recent era, scholarship has switched from personal to organizational professionalism**.** In this view, professionalism describes the relationship among colleagues, patients and the society as a whole (Ojuka, Olenja, Mwango'mbe, Yang & Macleod, 2016)**.**

2.3. Defining Professionalism

Sifting the literature for a definition of 'professionalism', there are two main components of the definition: one is descriptive and the second is normative. Many definitions include both descriptive and normative aspects. These generally admit some vital descriptive features of professional knowledge (complex and extensive); training (throughout life); practice (expert application of knowledge and difficult to analyze); together with a set of co-values which professionals should illustrate - for example, passion, equality, integrity, honour, altruism and service (Jha, McLean, Gibbs & Sandars, 2015).

According to Swick (2000), a profession is an explicit type of activity that is performed by an individual with particular characteristics while competing for economic, social, and political rewards. There are some main characteristics of professionals which separate them from non-professionals. Firstly, they have specific knowledge of their field and they make a firm personal pledge to develop and improve their skills. Secondly, they have the degrees and certifications that provide the bases of their knowledge and skills; and finally, professionals are expected to abide by a code of ethical practice specific to that profession (Swick, 2000).

The Royal College of Physicians and Surgeons of Canada (2000) states that the term professionalism covers the meanings of expertise, mind-sets, actions and behaviours which one expects from the professional during the practice of his/her profession(Royal College of Physicians and Surgeons of Canada, 2000). It includes good manners, veracity, sincerity, altruism, impartiality, respect for others and self-management. A person who practices the same activities in his daily routine develops special skills. The skill aspect is still tacit in traits of professionalism such as 'excellence' because one cannot attain excellence without being skilled (Wearn, Wilson, Hawken, Child & Mitchell, 2010).

It is worth noting that not all categories of work have an established core of knowledge or the academic qualifications that go with this. Not all vocations require a wide knowledge base to practise effectively and successfully and not all professionals have top degrees in their fields (Dogra *et al.*, 2009). What matters, though, is that those workers called professionals have worked in a serious, thoughtful, focused and sustained way to master the specialized knowledge needed to succeed in their fields; and that they keep this knowledge up-to-date, so that they can continue to deliver the best possible of what the profession has to offer (Swick, 2000).

Eraut (2000) described a competent clinician as one who is able to think, feel and act like a proper physician. He stated that professional competence includes communication, knowledge, technical skills and clinical reasoning. Zafiropoulos (2017) adds to the above the ability to solve problems, providing clear and definitive solutions through professional competence. He argues that such an ability tolerates uncertainty and requires the correct attitudes, ethical behavior, altruism, respect for others and self, honesty, integrity and ability to self-regulate while maintaining a high degree of competence and a belief and application of the profession's code in addition to the profession's knowledge and skills. These arguments are similar to those of others (Swick, 2000; Wear and Castellani, 2000). De Rosa

(2006) believes that professionalism is 'the practice of doing the right thing, not because of how one feels, but regardless of how one feels'. Lesser *et al*. (2010) suggest that another important characteristic of professionals is that they do not make excuses, but focus on finding solutions.

Professionalism as a list of attributes:

There are others who define professionalism through a list of attributes (Wear and Kuczewski, 2004). The most common definitions articulate lists of measurable expectations from attitudes derived from each suggested value (Lesser *et al*., 2010)**.** In their study, Peggy Wagner and her colleagues concluded that all healthcare professionals exhibit at least some if not all attributes and virtues related to professionalism (Wagner, Hendrich, Moseley & Hudson, 2007). According to that study, when analysed in relation to the American Board of Internal Medicine Physicians' Charter, the main characteristics which could define the level or extent of professionalism are appropriate knowledge and technical skills. Honesty and confidentiality were found to be the most common factors in developing the doctor-patient relationship. Moreover, personal character also counted towards positive professional behaviour. It was observed that attributes related to social accountability and inclusivity were most commonly found lacking. Wagner *et al*. (2007) concluded that healthcare professionals, nevertheless, have a desire to gain professionalism education and training**.**

According to Wynia, Papadakis, Sullivan & Hafferty (2014), definitions given in the form of lists of attributes of professionalism are perhaps applicable to educate, measure and certify. They state that, first of all, reducing professionalism to a list of professional ethics, characteristics or attitudes is not appropriate because professionalism demands behaviours. Secondly, professionalism described merely by a list of desired attitudes risks being misunderstood as a status which people may obtain by analysing the essentials of the list.

Lastly, to describe professionalism as a construct of individual attributes proclaims that professionalism is mainly functionalised at the personal level, diverting focus from the necessary activities of the group which underscore professionalism. Swing (2007) also proclaimed that professionalism was not merely the behaviour of an individual. He argued that professional competence is a reflection of the professional competence of the healthcare provider and needs to be examined as a whole.

Walsh and Abelson (2008) also claim that a list of attributes of professionalism, considered without context, adds to further confusion. Martimianakis, Maniate & Hodges, (2009) also discourages a focus on attributes, values and characteristics in defining professionalism, calling such constructs a shaky foundation for the concept and the development of its understanding, teaching and training, assessment and evaluation. He concludes with a call for contemporary sociological literature on professionalism taking up greater prominence in this domain. However Shukr (2014) identified that medical professionalism was still being conceptualized in terms of attributes and values in Pakistan, at least up till quite recently.

Professionalism as a set of moral values

Kinghorn (2010) in his article on Aristotle's concept of 'professionalism' states that it cannot be acquired in the concrete. The moral excellence that Aristotle's professionalism aspires to can only be acquired through a long process of practice, apprenticeship and internship under careful guidance and concrete supervision by teachers who themselves personify and embody these moral excellences. According to Aristotle, 'practical wisdom' forms the basis of the guiding logic of medical professional identity transformation (Kinghorn, 2010). Professionalism according to Aristotle, therefore, is a set of values and a

morality framework acquired under mentorship and is directly dependent on the moral character of both the student and his teachers (Brainard and Brislen, 2007).

Ginsburg and Stern (2004) make a case for a sound theoretical basis for this clinical and moral excellence that helps embed the same into the character and personality of its subjects. According to Aristotle, all this requires to be firmly grounded in a community; a community that appreciates and practises the same moral excellence and allows space for conditions in which it can flourish (Kinghorn, 2010). This is at both the institutional and the societal level.

Such values may also characterize a good doctor-patient relationship. Ojuka, Olenja, Mwango'mbe, Yang & Macleod (2016) argue that a balanced doctor-patient interaction is the major goal of medicine in the modern era. They see professionalism as a set of ethics associated with healthcare and describe a vivid array of virtues in the healthcare providers. Professionalism seeks ethics: however, much more of ethics nowadays is dealt with by rules and principles (Brody & Doukas, 2014). Such principles and rules can be highly useful for ethical deliberation. Brody & Doukas (2014) note that education associated with professionalism seeks transformational change in medical values, ethics and humanities. Educators have a central role in professionalism for the development of the physicians (Ojuka *et al.*, 2016).

Sociological perspectives on professionalism; the 'third logic'

Freidson conceptualised professionalism as the 'third logic' following the logics of free market and bureaucratic managerialism. In his opinion these are the three organizing principles of the division of labour. He argued that only professionalism is capable of handling knowledge that is esoteric, not on account of being secret, but because it specifically pertains to that profession, it is therefore specialized and takes time and effort to acquire and

master. Freidson further postulated that professionalism needs to be rooted in "a set of interconnected institutions providing the economic support and social organization that sustains the occupational control of work" (2001 p.2). Professionalism is affected by any changes that take place at this institutional level.

Freidson refers to the sense of practical and institutional ethics as the soul of professionalism (2001 p.180). He maintains that professional control is legitimately monopolistic because it governs a special knowledge that is valued enough by the society at large (rather the society's representative elites) that they want its advancement for application in a socially productive and useful ways. He believes that the carriers of that special knowledge need to be protected by the society from market laws and reasons of state. In his opinion the structural underpinnings for the logic of professional control include specialized knowledge, protected jurisdiction, orderly careers in a sheltered market, professionally controlled training and a special ideology.

Freidson goes on to argue that no matter how specialized professionals may claim their competence to be based on this training and knowledge, it is still subject to the culture's stereotypical assumptions. Knowledge and competence, he argues, is both the formal codified variety the training institutions claim to transmit as well as the hidden non-codified knowledge and competence, especially the attributes that are socially constructed and are not part of the overt curriculum. This can in fact lead to tensions between the perceived or taught role of the professional against the role the society and the community expects from that profession.

Friedson (2001) further argues that there may exist within a community of practice marginalized professionals who have not been granted the same degree of access to the profession within the labour market for various reasons and it is at these margins of the profession that the values of the market erode professional values and vice versa. This in turn

is one of the main reasons for loss of professional control at the fringes of the profession within the labour market structure.

Other writers have discussed the interplay of market forces with the concept of professionalism. Cruess, Cruess & Steinert (2010) argue that the market forces in the United States of America have pushed physicians to become entrepreneurs in a competitive commercial environment with a resultant shift in their behaviour. This echoes the views of Starr (2008) and Relman (2007) who argued that cost issues in a free market state would continue to dominate policy debates regarding of the relationship professionals have with their peers and their clients. He argued that the so-called empowerment of the consumers had the potential to stress the doctor-patient relationship, while expanded case management could lead to issues like corporate control.

White (2004) postulated that for professionalism in medicine to maintain its status, evidence-based medicine and training initiatives were required to prevent medical errors. This, he believed, should be augmented with a policy of improved monitoring of the profession by the professionals themselves and better co-ordination. He encouraged a move to initiatives that promote patient safety.

Latham (2002) believed that these arguments also conformed to a 'Parsonian' or structural functionalist view of medical professionalism. This view maintains that the proper exercise of medical authority necessitates ensuring that the interests of individual patients are aligned with that of the society at large. Society looks to the institutions that harbour and transmit the competence and knowledge required for the profession - schools, hospitals, professional journals - to secure the competence and ethical behaviour of its professionals; helping to ensure that the professionals' exercise of authority and autonomy of function is never challenged by private financial interests or by political power (Latham, 2002). The role of these institutions is to ensure that such competence is transferred and maintained. Latham

argued that professionalism at any point in time lies in the collective mindset of the society. Professionals on their part need to continually strive to gain the trust and confidence of the clients they serve, to be viewed as trustworthy by both individual patients and the society at large.

Rothman, Blumenthal & Thibault (2020) argue that, within this 'third logic' conceptual framework of professionalism, an increasing number of physicians being salaried and employed by hospitals and health facilities together with the emergence of the 'information-savvy' patient further complicates the relationship between the doctor and the patient as well as the views of society at large. They argue that in this changing social and cultural climate it is all the more important for the profession to focus on putting the interests of the patients first, maintaining and enhancing physicians' medical competence and sustaining trust in the doctor-patient relationship. They maintain that an institutional culture that promotes professionalism and encourages physician leadership could be the solution, while at the same time safe-guarding the physical, mental and financial interests of the doctors. They believe that the solutions to emerging challenges have to come from the profession itself while it still holds the autonomy to manage its affairs.

At the same time Hohenstein & Levy-Todter (2020) support the role that cultural diversity in both the society and the healthcare workforce has on the drivers of labour market forces that challenge the status of the professional. These same market forces and the changing socio-cultural environment that demands greater accountability from the professional is also driving the professionals into rethinking their role within their community of practice. The rise of the hybrid professional workforce, such as a managerial physician workforce within the profession, is not just changing how the professional institutions are structured and function but is also changing professionalism as it is currently understood and practised (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). McGivern et al. believe

that this hybridization is integrating professionalism and managerialism, creating a more legitimate hybrid professionalism in the managerial context. They argue that because of their managerial positions such hybrid physicians are gravitating into a separate elite class that is redefining practice and professionalism from a managerial perspective.

Bioethical perspectives on professionalism: the doctor-patient relationship

It has been argued that to understand professionalism in medicine, two perspectives exist. One is dependent on sociological aspects and the other one on bioethics. As evidenced above, in the sociological literature much relevant work is available whose principal focus relates to the organisation of community and the organisation of work. Although the doctor-patient relationship has not been completely ignored in the literature of social sciences, the foremost concern has been the relationship between healthcare systems and the culture (Cruess and Cruess, 1997; Hafferty, 2006).

Bioethicists have focused on other facets of professionalism. Their focus has mainly remained on the relationship between the patient and his or her respective doctor, which emphasizes the value of medication as a moral effort. When the interface between medicine and society is judged, that judgment stresses the value of service to the public and public interactions.

Doukas *et al.* (2013) argue that the nourishment of professionalism is dependent on initially addressing the dysfunctional features of present systems of healthcare delivery and financing the desired objectives of medical education. Over and above this, they call for both ethicists and humanities educators to address the need for a uniformity of vision and to amalgamate objectives in understanding how their disciplines enhance professionalism. The advancement of the ethics and knowledge embedded in humanities with the attitudes and proficiency that enhance professionalism ought to improve patient care. Doukas *et al*. add

that this patient care can be analysed for its unique role within an educational process geared towards producing this outcome**.**

Hence, intrapersonal features of professionalism are vital to professionalism as a whole. Variations in choices of treatment, level of patients' knowledge, culture, presence of medical knowledge and rates of morbidity have all assisted the expectations of change and alternative options (Mechanic, 2008). Patients' perceptions of doctors' 'empathy' are clearly associated with their overall satisfaction with medical care and their ranking of physicians' professionalism. The term "empathy" is defined as the capability to develop awareness and understanding of patients' experience to provide proper assistance (Mechanic, 2008). Deficiency of empathy among physicians has also been shown to predict unhealthy clinical performance (West & Shanafelt, 2007).

A study by West and Shanafelt (2007) suggests that humanism and empathy are among some important elements of professionalism which are found to be reduced during the residency training period. This corrosion of professionalism seems to be associated in part to personal features, including individual distress felt in training, individual traits of personality and interpersonal skills**.**

Is professionalism inherently indefinable?

Bryden, Ginsburg, Kurabi & Ahmed (2010) concluded that up until 2010 there was no consensus on the definition of professionalism and attributes of professionalism had also not been codified completely. Others agree that there exists no overarching definition against which medical professionalism can be studied, practised and taught (Archer, Elder, Hustedde, Milam & Joyce, 2008; Walsh and Abelson, 2008).

Erde (2008) announced that he did not strive for a clear and unambiguous definition of "professionalism" because he believed that such a definition did not exist. Baldwin (2006)

considered professionalism as only a value-oriented, ideologically-based construct. Smith (2006) in his editorial described professionalism as a loaded and poorly defined word and quoted George Bernard Shaw who argued in 1906 that all professions deceive the common people and exploit the public only to try 'to reassure it with lies of breath-believing brazenness'. Shaw wrote

> 'All professions are conspiracies against the laity…all that can be said for medical popularity is that until there is a practicable alternative to blind trust in the doctor, the truth about the doctor is so terrible that we dare not face it' (Smith, 2006 p.49).

Birden *et al.* (2014) noted that there then existed a vast body of literature on the subject and yet the definition of professionalism remained as elusive as ever. In their systematic review they identified major conceptual divides over whether professionalism should be viewed as an overarching ethos grounding an approach to medical practice or as a set of attributes only. Birden *et al*. saw the terms 'professionalism' and 'humanism' as synonymous, considering professionalism as the art that complements the science in an effective, 'rounded' physician (op. cit. p.47). They concluded that

> 'there is no overarching conceptual context of medical professionalism that is universally agreed upon. The continually shifting nature of the organizational and social milieu in which medicine operates creates a dynamic situation where no definition has yet taken hold as definitive' (Birden *et al.* 2014 p.47).

They go on to describe the traditional elements of professionalism as:

> '1. Autonomy in action and self-regulation by members of the profession.
> 2. An identified moral code developed by the members of the profession, to which one pledges (vows) to adhere to.
> 3. A separate, distinct place (status) within, but at the same time outside of, the society in which they practise, and
> 4. A particular corpus of knowledge developed and maintained from within the profession which serves as the basis of the practice' (p.47).

On these four elements of the profession there is some consensus amongst various scholars (Freidson, 2001; Bloom, 2002; Krause, 1999). Freidson (2001 p.122) saw

professionalism as ‘independence of judgment and freedom of action.’ He argued that the special privileges and protection that professionals claim is based on their claim to a competence that is unique to that profession. They claim this through signaling legitimate credentials in the market. Training and education institutions therefore hold importance for maintaining professionalism.

Burford, Morrow, Rothwell, Carter & Illing (2014) argue that it may be better to assume that ‘professionalism’, as a distinct construct, does not exist. Individuals tend to develop certain behaviours and attitudes that best suit their physical, psychological and social assimilation in an organizational culture (Jha et al., 2015). Monrouxe, Chandratilake, Gosselin, Rees & Ho (2017) encourage

> ‘global medical educators to look beyond a one-size-fits-all approach to professionalism and to recognize the significance of context and culture in conceptualizations of professionalism’ (p.718).

2.4 Cultural Theories

The ideas, customs and social activities of a specific group of people or society are called *culture* (Handler, 2003). Cultural drivers mean the factors or the actions that persist in a society, which can define the overall thinking, actions and dealings of that society (Laland & Hoppitt, 2003). There is no doubt that these drivers have their impact on many aspects of life in any specific region. This study aims to compare the cultural aspects which influence the learning, practice and perception of medical professionalism in Pakistan with the rest of the world. Cultural theory will be discussed first as a support to the idea that culture has an impact on behaviours and professionalism.

Kluckhohn (1962) believes that culture is to society what memory is to individuals. Human behavior and various aspects of human life are influenced by various dimensions of

culture (McCort and Malhotra, 1993). Soares, Farhangmehr and Shoham (2007) attribute one of the earliest definitions of culture to Tylor, (2004) who explained culture as the complex whole which inculcates art, beliefs, customs, knowledge, morals and other capabilities and habits that are acquired by an individual as a member of the society. Soares *et al.* (2007) note that culture varies from other macro- environmental factors such as political, economic, religious, legal, linguistic, technological, educational, industrial and others. However, Yoo, Donthu and Lenartowicz (2011) considered it unfeasible to isolate purely cultural variables from macro-environmental influences as patterns of socialization and culturally normed behaviors often stem from a mix of political and economic exigencies, religious beliefs and so on.

The choice of dimensions that are most appropriate and suitable for operationalizing and conceptualizing culture have been developed by a number of researchers over time (Inkeles & Levinson, 1969; Hofstede, 1984, 1991; Bond, 1987; Dorfman & Howell, 1988; Keillor & Hult, 1999; Schwartz, 1999; Smith, Dugan & Trompenaars, 1996; Steenkamp, 2001).

The most widely used cultural framework in marketing, psychology, sociology, management sciences and other disciplines is the one developed by Hofstede (Steenkamp, 2001). Hofstede undertook an empirical study based on 116,000 questionnaires provided by 60,000 respondents from seventy countries (Hofstede, 1984; 1991; 2001). He created six dimensions linked to political, economic, demographic and geographic aspects of a society. On each dimension indexes were assigned to all nations that were part of the study.

This framework is considered to be the most robust and comprehensive in terms of the number of samples of national cultures (Smith *et al.,* 1996; Dugan & Trompenaars, 1996). It has also been used for formulating hypotheses for various comparative cross-cultural studies.

Soares *et al*. (2007) claim that a high level of convergence supports the theoretical relevance and further justifies the use of his dimensions.

Individualism vs. Collectivism:

The first dimension describes the degree to which a person identifies himself as an individual rather than identifying with a group (Hofstede, 1994). Relationships within cultures are described by this dimension. In the individualistic society people take care of themselves and their immediate family whereas in collectivistic cultures individuals belong to groups to which their loyalty is given in exchange for the group looking after them (Triandis, 2001). According to Chan & Cheung (2016) and Rinne, Steel and Fairweather (2013), people oriented towards individualism are more independent, autonomous, success-oriented, self-contained and calculative than those who are oriented towards collectivism. Individualism allows people to place greater value on personal opinions and privacy whereas collectivists give importance to the interests of the group and value interdependence (Hofstede, 2001). A positive relationship has been found between a need for achievement and individualism as individuals are motivated by personal goals in contrast to collectivists who place more emphasis on sharing, cooperation and group goals over personal goals (Spence, 1985).

However Hui (1988) considers these two cultural orientations to be independent constructs that exist as tendencies within all individuals and societies.

Uncertainty Avoidance:

The second dimension describes the level to which people are threatened by ambiguity and uncertainty and try to avoid such situations (Hofstede, 1991). This dimension caters to the need for well-defined rules for prescribed behavior (Soares et al., 2007). According to Hofstede (2009), uncertainty avoidance indicates the extent to which a culture enables the

members of a society to feel either comfortable or uncomfortable in unstructured or unexpected situations - unknown, novel, unusual and surprising.

Hassan (2019) stated that the cultures that avoid uncertainty try to reduce the possibility of such situations by adopting strict rules and laws, security and safety measures; and that people living in such cultures tend to be more emotional and intrinsically motivated via inner nervous energy. In contrast, cultures that accept uncertainty tolerate differences in opinions and perspectives, in addition to having very few rules and allowing many currents to flow side by side (Hofstede, 2009). Moreover, people from such cultures are more contemplative and phlegmatic (Hassan, 2019).

Power Distance:

The third dimension, power distance, depicts the consequences that are derived from inequality of authority and power relations in a society which influences the hierarchy and dependence relationships in organizational and family contexts (Soares *et al*. 2007). All societies are somewhat unequal but the degree of inequality differs significantly (Hofstede, 2009). The power distance dimension reflects the extent to which the members of the society accept the distribution of power (Hofstede, 2009). Basabe & Ros (2005) suggest that the levels of inequality in a society are endorsed by followers as much as by leaders.

Masculinity vs. Femininity:

This dimension describes the dominant values of the society. In masculine cultures, the dominant values are success and achievement whereas caring for others and quality of life are the elements of feminine cultures (Soares *et al.,* 2007). Paechter (2006) noted that this dimension of culture refers to the distribution of roles between the genders which is another vital issue for any society. Feminine values are related to modesty and caring in contrast to masculine values that favor assertiveness and competition (Hofstede, 2009).

Long-Term vs. Short-Term Orientation:

A long-term orientation reflects the nurturing of virtues that are oriented towards future rewards, in particular thrift and perseverance (Hofstede, 2001). These are regarded as Confucian values and this orientation has been termed 'Confucian Dynamism' (Soares et al., 2007). Hofstede (2009) contrasts these to the short-term orientation that values respect for tradition, protecting one's face and fulfilling social obligations.

Indulgence vs. Restraint:

Indulgence refers to the extent to which impulses and desires are controlled by individuals based on the way they were raised (Enkh-Amgalan, 2016). According to Hofstede & Minkor (2010), indulgent cultures are the ones that have weaker control over their desires. They allow free gratification of natural and basic human desires that are related to having fun and enjoying life whereas restrained societies have a belief that such gratification requires to be regulated and curbed by the existence of strict rules and norms. There are three sub-dimensions related to the indulgence versus restraint dimension: life control; happiness and pleasure in life; and importance of friendship and leisure (Chudzikowski, Fink, Mayrhofer, Minkov, & Hofstede, 2011).

Hofstede's cultural theory suggests that there may be many dimensions to be regarded during the study of the effect of culture on the socio-cultural structure of a certain region or country. These dimensions include the share of power in the community (the degree of injustice and the extent to which less powerful members of the society feel it); individualism versus collectivism (the extent to which members categorise themselves as part of a group); masculinity versus femininity (the division of roles between males and females); avoidance of uncertainty (how easily knowns, unknowns and uncertain conditions can be managed in the society), indulgence vs. restraint (the extent to which impulses and desires control

individuals in the society) and long-term versus short-term perspectives in people's attitudes and thoughts. All the above factors can be helpful in understanding any cultural variations observed.

Generally speaking, western cultures (in Europe, the UK and North America) focus more on individualism (they lay more stress on individual progress, value individual personalities and independence, and hence are relatively less socially focused); they manage unpredictability (they prefer guidelines to rules, indulge in informal works and are hence ready for various opinions); and they relate to short-term results (they are motivated by immediate stability). In contrast, Asian cultures are relatively more collectivist (they give weight to the long-term good of the group and hence social orientation is relatively dominant); they are powerful in avoiding uncertainty (they give weight to formal activities and hard rules so are less tolerant to dissent); and they show a more long-term orientation (they value activities and behaviours that influence the future). Eastern cultures tend to appreciate tolerate more power distance than Western cultures (Chandratilake, McAleer & Gibson, 2012).

The work of Hofstede has simultaneously been praised enthusiastically and criticised. It has been argued that the inferences he has drawn from the results of his study are too generalized (Jones, 2007). Can the behaviour of a very particular subset of a society be generalized to refer to the entire society? This is the main criticism that Hofstede faces. Graves (1986) argues that a study focusing on only one company cannot possibly account for the entire cultural system of the country. His views are supported by Olie (1995) and Sondergaard (1994). Dorfman and Howell (1988) question the integrity of the questionnaire used by Hofstede in his study and the resulting analysis. They argue that Hofstede on accession has used the same questionnaire for different discussions. McSweeny (2001) claims

that the sampling in the research study carried out by Hofstede was flawed. He believes the sample was sparse and unevenly distributed. However, Sondergaard (1994) in his analysis of studies replicating Hofstede's identifies that the majority of these 61 studies have confirmed the results of that of Hofstede.

According to Morrow, Rothwell, Burford & Illing (2013), Hofstede's cultural dimensions theory can assist in understanding the adaptations a few physicians have to make in managing to work in the UK National Health Service. They claim that it may enhance consciousness, understanding and greater cultural proficiency among the ones who are working under supervision in their respective training (Appendix II).

Another body of theory, cultural values theory, highlights seven norms on the basis of which the cultures of various countries and regions can be assessed (Schwartz, 1999). These are: conservatism (stress on maintenance of dignity for social order, culture, and security of family including wisdom); intellectual autonomy (valuing of creative ability and open-mindedness); affective autonomy (wish of persons to personally pursue joy and enjoyment); hierarchy (acceptance of the unjust division of resources, roles and powers); egalitarianism (willing promotion of betterment of others to acquire freedom, justice in society, and equality); mastery (development via self-realisation and success by proficiency), and harmony (broad mindedness in society). Cultural values theory suggests that Eastern cultures are comparatively more conservative and hierarchal and give weight to mastery to some extent; whereas European cultures are comparatively independent, harmonious as well as egalitarian; and the North American culture seems to be really autonomous and give weightage to mastery fully and completely. However, to some extent the significance of these generalizations may differ among countries within particular regions (Chandratilake, McAleer & Gibson, 2012).

Culture is thus an ambiguous concept that raises conceptual, definitional and operational obstacles for research (Soares et al., 2007).

2.5 Professionalism from a Cultural Perspective

A profession always displays certain cultural and social nuances wherever it functions. Ojuka *et al*. (2016) argue that over the last few decades, progress in knowledge and skills has altered the nature of all professions in general but especially medicine. They argue that nowadays professions have become more closely associated with the application of as perfect a body of knowledge as possible and relatively less associated to work which is central to the well-being of people.

Holtman (2008) argues that an individual professional's conduct and the social reaction to that conduct are inseparable. It is the social reaction that drives that conduct. Alternatively, the collective social conduct of the physician community of practice drives the individual physician conduct and the society's response to it. This he believes is on account of the individual's and the collective's adjustment to professional norms co-varying with other social and psychological phenomena in the society. Cruess & Cruess (2016) suggest that this is the reason why professionalism is expressed, understood and projected differently in almost every country of the world. In their opinion culture and social expectations play a more important role in defining professionalism than the structure and governance of the healthcare system; a view presented elsewhere in the literature (Hafferty & McKinlay, (1993); Krause, 1999).

Coulehan (2005) also claimed that professionalism was a social phenomenon and culturally sensitive. He suggests that a dedication to moral attitude associated with that which is held most sacred within the society, and a solid understanding of its ethical and moral

fabric as a consequence of sharing norms and beliefs, are important aspects of medical professionalism.

However the importance of cultural variation in the understanding of professionalism has been the subject of only a few studies, most likely because of the practical hurdles of conducting this type of research. Sattar, Roff and Meo (2016a) described similarities and differences in the understanding of professionalism of undergraduate medical students and faculty teachers in one medical institution in Saudi Arabia. The respondents completed a bilingual (Arabian and English) version of the Dundee Polyprofessionalism Inventory I: Academic Dedication. Based on their findings Sattar *et al*. recommend improvements in the learning and training of medical professionalism keeping in mind the cultural context.

In another study, Sattar, Roff and Meo (2016b) compared medical students of the College of Medicine, King Saud University Riyadh (KSU), and students from pre-medical colleges in Egypt, again using the Dundee Poly-professionalism Inventory I: Academic Integrity. Respondents rated the significance of professionalism lapses by choosing from a hierarchical menu of sanctions. The study showed about a 77 percent variation in the behaviour of both groups which included items such as “physical assaulting a university employee or student” and “plagiarising work from a fellow student or internet publication”. 23%of responses showed similarities in items such as “lack of punctuality for classes and drinking alcohol over lunch and interviewing a patient in the afternoon”. The study concluded that there were more differences than similarities associated with the understanding of professionalism between the two cohorts.

Chandratilake, McAleer & Gibson (2012) presented evidence of regional and geographical variations in the beliefs, behaviors and attitudes that are believed to constitute

professionalism. They carried out a survey on 584 doctors belonging to two countries and in order to report their findings they used Hofstede's cultural dimension theory (Hofstede, 2001) and Schwartz' cultural value theory (Schwartz, 1999). The authors reported considerable regional differences in what respondents regarded essential attributes, alongside reasonable consensus. The authors attributed these differences to socio-cultural factors. Their findings were similar to those reported by Schmidt, Rees, Greenfield, Wearn & Dennis (2004) who suggested the existence of a counter-cultural response, explaining that attitudes are linked to demographical and education – related characteristics.

Across various cultural contexts the professionals and lay public alike may well consider professionalism as a single construct. To highlight how professionalism is conceptualized by clinicians, patients and students, Ojuka *et al*. (2016) conducted a study in a teaching hospital in Kenya through focus group discussions and detailed interviews using a Likert scale for responses. 'Respect' between colleagues and towards the patients was identified as the most common factor relevant to professionalism. The authors concluded that for the curriculum of professionalism to be relevant to the Kenyan context, dignity and respect as cultural values ought to be an essential aspect (Ojuka *et al*., 2016). Ojuka *et al*. (2016) claim that respect for patients and listening to their problems with sincerity is an important aspect of professionalism in the paternalistic model of the patient-doctor relationship, where the role of a patient is to describe his or her condition fully and truthfully to the physician, cooperate with the physician and believe in the treatment and recommendations of the physician.

A study was done at a medical institution in Pakistan to analyse how Pakistani and Pakistani-heritage students identified the features of professionalism of an ideal medical physician (Akhund, Shaikh & Ali, 2014). Another goal of this study was to find students'

preferred methods of learning professionalism. The medical students perceived professionalism as vital to their professional learning and practice and there was no difference in this perception throughout the various study years. Internal commitment to each aspect of professionalism was high in various years. It appeared that faculty role models, case-based training and role plays could be used to highlight professionalism challenges.

Al-Ansari and his colleagues conducted a study in the cultural setting of the Middle East in 2015 using the capacity to work within the cultural environment and the psychological characteristics of various respondents as a measure of professionalism. A military hospital in Bahrain was used for the data collection. All interns of a given year were included. Every participant was assessed by three groups of raters. The study concluded that there are professionalism challenges within the Middle Eastern culture which are unique to the region including but not limited to patient autonomy and maintenance of patient confidentiality (Al-Ansari *et al*., 2015).

Tsai, Lin, Harasym & Violato (2007) conducted a similar study to identify underlying factors in the understanding of medical professionalism in Taiwanese students. The three constructs declared most significant were: ‘answerability to patients’, ‘dignity for patients and their families’; and ‘dedication and devotion’. One of the least important aspects as reported by students regarding professionalism was ‘enduring unavoidable risks to oneself when a patient‘s welfare is at stake’. Factor analysis indicated that mean scores of factors was from 3.84 (factor: commitment to care) to 4.7 (factor: respect of others) (Tsai *et al.,* 2007). Thus in this study the perception of students regarding traditional professional approaches for teaching professionalism are significant in that they identify gaps in professional progress and teaching and training requirements, as well as the measurement and assessment of professionalism.

In carrying out health research, Al Bannay, Jarus, Jongbloed, Yazigi & Dean (2013) called for factors associated with culture and cultural differences to be consulted, understood or controlled together with the objectives of the study, to enhance the reliability, authenticity, and generalizability of study. An article by Field, Ellis, Abbas & Germain (2010) demonstrates how cultural aspects influence results in health promotion studies. They define how change within and among cultures can be regarded within a study, for example, the conceptualisation of the study questionnaire or hypotheses, and the strategy including grouping, analysis, and interviews. They supply various illustrations of how culture affects the study outcomes and answers. Improperly accounting or controlling for cultural differences in the conduct of health studies, either planned or unplanned, may lead to inappropriate data gathering, inappropriate study design, false conclusions reached and inadequate generalizability of the outcomes.

Bagchi, afUrsin and Leonard (2012) assessed cultural perspectives on healthcare quality. They explored cultural variations in understandings of attributes of care through an analysis of available studies, for example, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaire. Their study addressed perceptions of healthcare quality among members of ethnic and racial minorities. Eight groups were consulted including African-American, Latinos, Whites and Asian Indians. The study materials were categorized into two 45-minute segments. In one of the segments, the participants gave a rating to the quality of care shown in a video; the concept of "healthcare quality" was discussed in another video. Results indicated that members of ethnic and racial minority groups are more likely than whites to recognize cultural proficiency and a comprehensive approach to care as significant in relation to the quality of healthcare. However, none of these ideas is presently added to the core CAHPS questionnaire. Thus the authors conclude that the CAHPS and

other quality studies may not adequately deal with concepts of healthcare quality that the members of these minority groups account most significant.

A study by Chandratilake, McAleer and Gibson (2012) identified 46 professional attributes by reviewing the literature and asked a total of 584 medical practitioners, representing the UK, Europe, North America and Asia, to indicate the importance of each of these attributes. The study recognized similarities and dissimilarities at regional level in the understanding of professionalism, many of which could be explained by differences in culture within the concepts of cultural values and cultural dimensions. However, specific dissonances between regions in areas of social well-being in the long-term, workplace values, and openness to patient-centered practices could be better attributed to socio-economic factors.

Another study was done in order to compare medical professionalism from two Chinese cultural perspectives. Ho *et al*. (2014) found similarities between the Taiwanese and Chinese frameworks in the context of dedication and morality due to the shared effect of Confucianism. They maintain however that the Taiwanese articulations of collective work, economic concerns and the promotion of health seem to be triggered by different political, social, and economic aspects than those of mainland China. The study depicts the significant effect of cultural norms, the healthcare system and social history on the foundation of medical professionalism and seeks for more research to choose global frameworks to adjust certain local contexts into the framework of professionalism.

A study on Chinese physicians indicated healthy behaviours towards professionalism values (Chen, Xu, Zhang & Fu, 2013)**.** The authors noted that the attitudes of the participants were not uniform with their behaviours, mainly in the areas of perfection as well as

betterment in quality and self-management. One of the appropriate ways to promote Chinese physicians' professionalism might be through improving management of health centers, that is, their governance structure (Chen *et al*., 2013)**.** Nie, Smith, Cong, Hu and Tucker (2015 p.48) in their paper on transcultural interpretations of medical professionalism in China and the US write:

> "Chinese culture and traditional medical ethics are broadly compatible with the moral commitments demanded by modern medical professionalism. Methodologically and theoretically—recognizing the problems inherent in the hoary but still popular habit of dichotomizing cultures and in relativism—a trans cultural approach is adopted that gives greater (due) weight to the internal moral diversity present within every culture, the common ground shared by different cultures, and the primacy of morality. Genuine cross-cultural dialogue, including a constructive Chinese-American dialogue in the area of medical professionalism, is not only possible, but necessary".

The debate over the definition and attributes of medical professionalism is obviously linked to how the concept is understood or viewed in different regions of the world. In the West it differs particularly between the UK and the US contexts. Coulehan (2005) thought that the focus on professionalism in the US came about largely because of the perceived threat from commercialism. In contrast, Irvine (1999) claimed that it was a threat from bureaucracy that generated interest and debate over professionalism in the UK. Hafferty (2006) and Irvine (2001) consider the British approach to professionalism more patient-centered and that in the US oriented more towards doctors.

Focusing on context, culture and relevance, Puschel *et al*. (2017 p.11) define professionalism as:

> 'the medical conduct of excellence based on the respect of life and human dignity and in the virtues of benevolence, compassion, prudence, and justice'.

They emphasise the importance of language in the relevance of a definition of professionalism. They argue that language forms one of the dimensions of the context that helps individuals make sense of the concept. A study by Rothwell, Morrow, Burford and Illing (2013) also noted the social use of language as a sophisticated cultural skill that needed to be acquired.

There are thus a number of factors in professionalism which can be regarded as 'culturally specific'. In different countries, professionalism is understood from the perspective of one's own culture and hence, it is very important to discover the similarities as well as differences in the behaviour of the general public in different areas of the world.

Intercultural identity:

Lu (2006) argues that when we look at culture at the societal level it is seen to demonstrate mainstream tendencies, not involving all behaviors and all beliefs of all individuals within the society. He presents the model of 'cultural fit' also described by Jha *et al*. (2015). This model helps us to understand the behavior of individuals at various cultural levels within a society. If one dissects a society, it is constituted by individuals and groups at home, at work, at departmental, organizational, institutional and regional levels. Even in a mono-cultural society there will be cultural differences at these levels and more so in a culturally diverse society. In any cultural context if an individual is in accord with the belief and value systems of others he will be at ease, whereas he might experience challenges to his own belief, moral and value systems in a cultural context where these differ from those of others. This may lead to the individual entering in a state of cultural shock. Then, if adaptation occurs, that leads to the development of an intercultural identity.

Jha *et al.* (2015 p.75) take the view that 'culture represents the values, beliefs and behaviors expressed by an individual, which are socially constructed'. The authors argue that in a multicultural society, health professionals tend to internalize the values, beliefs, behaviors and attributes associated with the dominant culture within the society, and they do that through the process of socialization. In a culturally diverse society, health professionals will be bombarded with different values, beliefs and behaviors (Bennett and Bennett, 2004) leading to the development of an intercultural identity. Jha *et al*. (2015 p.74) conclude that it is important to study professionalism in the context of cross-cultural beliefs, attitudes and values. They argue that

> 'variations in perceptions of professionalism could potentially occur if values conflict when studying or practicing in a foreign culture'.

They believe that it is important that those individuals who cross cultural boundaries in pursuit of jobs should familiarize themselves with local cultural and social contexts related to professionalism. They propose that these professionals should be eased into this new system and helped to adjust by providing information and relevant training related to the local cultural contexts.

Struckmann et al., (2015) have commented that in the era of international movement of doctors, an ordinary understanding of descriptions which consist of proficiency to practise, its potential influence and impairment on the safety of the patient becomes truly vital. The Dundee Inventory may be useful for the induction of doctors who wish to work in organisational and national cultures that differ from those in which they were trained (Guraya, Norman & Roff, 2016)**.**

Bennett's (2017) model of intercultural development proclaims that with repeated cross-cultural challenges, a healthcare provider moves along a continuum from denial, then

polarization leading to minimization, followed by acceptance and finally adaptation. At this final stage, the healthcare provider can very safely be considered to have acquired an intercultural identity. Hammer (2011 p.475) further developed the model of Bennett into the intercultural development continuum, which he describes as:

> 'a movement towards greater intercultural competence/sensitivity, from a less complex set of perceptions and behaviors around cultural commonalities and differences (mono-cultural mindset orientations) to a more complex set of perceptions and behaviors (intercultural/global mindset)'.

In recent years, Dogra *et al.* (2009) note that cultural intelligence has emerged as an important attribute within medical professionalism. They acknowledge the potential risks of certain aspects of the healthcare environment (for example, cultural motives in illness representation and bias values in diagnoses) that represent a significant dimension of medical education. They describe doubt and misgivings as inherent to clinical practice. In their study students indicated various degree of tolerance for doubt and unpredictability that seem to demonstrate enduring behavioural practices towards technology, norms, culture and impartiality, and the requirements for self-assessment at the expense of cultural and situational sensibility. There were various ideas about what the term 'cultural diversity' implies and what ought to be the role of a cultural diversity curriculum. Students felt uneasy regarding the confusion that they felt as a result of cultural diversity, which led towards real stress. Dogra *et al.* (2009) compared this stress to the reflection and experiential learning which could occur if such training were to be provided beforehand

Ho, Gossenin, Chandratilake, Monrouxe and Rees (2017) applied a narrative interview method with 64 Taiwanese medical students while collecting narratives of professionalism dilemmas. They identified considerable tensions between the taught western medicine and the immersive Taiwanese culture, analyzing these using the intercultural

competence framework developed by Friedman and Berthoin-Antal (2005). Their study highlighted disengagement in most narratives from intercultural dilemmas. They supported greater attention on inter-cultural competence training.

Institutional sub-cultures:

The maintenance of an optimal level of proficiency and an adequate response to patient care can be described as participation in a sub-culture within individual healthcare environments (Mechanic, 2008). In a study by Sattar & Roff (2016) the results from a relatively small convenience sample suggested that there were different 'climates' or organisational cultures relating to academic professionalism in two different medical schools, one in Scotland and the other in Saudi Arabia. The Dundee Polyprofessionalism Inventory was again used to map respondents' understanding of the respective significance of lapses in undergraduate coaching in professionalism both within and between medical schools, enabling the identification of areas in which professionalism teaching and learning should be supplemented.

Capitulo (2009) notes a direct connection between teamwork, communication and patient safety, professional behavior and the healthcare organization's culture down to a unit or a particular service. She noted that the majority of incidences of code violations were by health professionals that spent a short tenure at her institution thereby affirming the author's claim that individuals require time to adapt to a new environment and culture and that the organizations should support individuals in doing so.

Cohen and Kol (2004) identified a relationship between professionalism and 'organisational citizenship' behaviour that itself is mediated by variables that represent justice in the organisational set-up and culture. They argued that higher levels of

professionalism allowed nurses to better understand their relationship with the organisation because this increases their sense that they are being treated fairly and justly.

Noordegraaf, Schneider, Van Rensen and Boselie (2016) analyzed cultural interventions in healthcare organisations that were aimed at overcoming challenges that led to clashes between organisational logics and the health professional. They concluded that the various cultural dimensions of the health professional domain should be counted and used as resources instead of restrictions in developing programs and projects that generate debate in, and training to, address and adapt under culturally challenging environments.

Matveevskii, Moore and Samuels (2012) concluded that teaching hospitals and health professions educational institutions should assume a role of supporting professionalism through improving teaching practices and techniques which were grounded in a professional culture.

While on the subject of teaching and training practices, it will be appropriate to cite the work of Al-Abdul Razzaq, Al-Fadhli and Arshad (2014). They surveyed 95 final year medical students at Kuwait University using open and close ended questions in order to determine students' experiences and views on the definition, teaching, learning, and assessment of professionalism. A total of 252 attributes describing professionalism were categorized by respondents, 98% of which were listed under the CanMEDS theme defining professionalism as dedicated to profession, patients and society via ethical practice.

The most useful ways of learning about professionalism for the students were meeting with positive role models, patients and their families, and relatives, and a sense of belonging. The authors identified a strong role of culture, amongst other factors, on medical students' development of perceptions of professionalism. They proposed that any framework of competencies created to address professionalism in the Arabian geographical region should be contextualized to Arabian culture.

The role of the 'hidden curriculum':

In the 1930s Flexner suggested that informal social institutions at workplace and beyond have an effect on what is learnt, how and why (Flexner 1936). Hafferty (1988) recognized the role of the hidden or tacit dimensions in the process of becoming a physician. The 'hidden curriculum' was identified by Berger (1963) as messages communicated by the organization and operations of schooling apart from the official or public statement of school mission and subject area curriculum guidelines. Berger went on to speculate that these messages usually deal with attributes, values, beliefs and behaviour. The roots of this concept can be traced back to John Dewey's (1938) concept of 'collateral learning', and William Heard Kilpatrick's concepts of primary, associate and concomitant learning. These theoretical concepts depict teaching and learning as a distinct social phenomenon or process.

The tacit learning from the hidden curriculum is also similar to the concept of 'situated learning' proposed by Cobb and Bowers (1999); or that of 'workplace learning' by Gherardi (2005); or even that embedded in 'communities of practice' described by Li et al., (2009). The basic premise of these learning forms is that social life in general is governed by a complex interplay of formal laws and/or cultural traditions, informal norms, social practices, taboos, superstitions and stereotypes.

Learning is embedded within this social life (Berger, 1963) and therefore is heavily influenced by this culture of social life. This makes the priorities, motivation, meanings of learning subject to the social and cultural context within which the curriculum or work/professional life is embedded (Bleakley, 2010). The effect of context, situation and culture on learning, including learning of professionalism and its subsequent practice therefore cannot be ignored (Lave & Wenger, 1991).

Hafferty (1988) explains that the hidden curriculum includes cultural norms that are transmitted through both formal and informal educational endeavors but are not necessarily

acknowledged to exist. In their writings, Hafferty and Franks (1994) make a case for recognizing the necessity of accounting for and helping faculty and students learn to understand and even analyse the hidden curriculum at play in their institution.

Monrouxe and Rees (2012) gathered 833 narratives of professionalism dilemmas from 200 medical students from three medical schools (in Australia, England and Wales). The narrative analysis identified that the students struggle as far as professionalism learning and training is concerned on account of contradictions between the formal and informal learning experiences that arise from a cultural clash. They recommend that students should:

> '(1) be encouraged to develop an awareness of professionalism issues within workplace learning environments through the formal curriculum; (2) be encouraged to develop ways of coping with these difficult situations; and (3) be empowered to speak up about professionalism lapses to reduce any negative emotional residue and promote cultural change' (op.cit. p.697).

Haidet and Stein (2006) argue that faculty too are learners in their own right within an institution. In fact the role of the physician as a learner never ends as one continues to learn socially. Glicken and Merenstein (2007 p.54) argue that

> 'while medical professionals share standards of medical practice in exercising medical knowledge, few have obtained formal training in the knowledge, skills and attitudes requisite for teaching excellence'.

They argue that every institution should strive to enhance the professionalism of educators without which any professional reform introduced into the system is likely to fail. They suggest that the culture within the hidden curriculum largely dictates outcomes of these reforms.

Shakour, Yamani and Yousefi (2016) in their qualitative study using semi-structured interviews of 24 experts in medical education gathered from all universities in Iran characterised five main categories or factors affecting teaching and learning professionalism

among medical teachers. These included culture, educational factors, background, attitude, and organisation factors. They proposed that the definition of professionalism in every society is different and is related to a society's culture. They concluded that no program of faculty development in professionalism can be designed without giving due consideration to culture; that of the institution, the organisation, the society and the community of practice.

2.6 Professionalism models from different cultures

Abdel-Razig et al., (2016) produced a consensus statement on a framework of professionalism derived contextually out of the Arabian culture:

> "Professionalism is a social construct influenced by cultural and religious contexts. It is imperative that definitions of professionalism used in the education of physicians in training and in the assessment of practicing physicians be formulated locally and encompass specific competencies relevant to the local, social and cultural context for medical practice" (Abdel-Razig *et al*. 2016 p.165)

The framework revolves around nine commitments.

1. Commitment to *Ihsan* (excellence) and adherence to ethical practice;
2. Commitment to advocacy;
3. Commitment to communication;
4. Commitment to *Itqan* (quality in work) and lifelong learning;
5. Commitment to education;
6. Commitment to empathy and compassion;
7. Commitment to integrity;
8. Commitment to respect; and finally
9. Commitment to embodying a sense of responsibility.

They conclude that their framework is informed by an Islamic perspective, yet they believe that it is the first secular definition of medical professionalism at least for the Arab

region. They argue that this definition is rooted in the unique religious, social and cultural context of their region.

The Four-Gates model of Al-Eraky, Donkers, Wajid & van Merrienboer (2014 p.S13) resulted from a Delphi study over three rounds using seventeen experts from diverse disciplines. It is presented in Figure 2.1 below, reproduced from their published work:

Figure 2.1: The Four-Gates Model of Arabian Medical Professionalism

The numbers represent the following ideas:

1. Self-awareness, recognize own potentials and limitations;
2. Self-management; balance between personal and professional roles;
3. Excellence and commitment to professional development;
4. Reflective practice;
5. Respect for patients, colleagues and students;
6. Keeping professional confidentiality;
7. Self-accountability for own behaviours;
8. Self-motivation: expecting reward from God, not people.

The authors believe their model represents a pathway that is applicable to faith-driven societies. In fact, they believe that this model may be quite specific to Islamic societies and even to Arab Islamic societies. The authors conclude that their study points to the divergent nature of the interpretation and understanding of medical professionalism in the West and the Arabian countries.

Ho, Yu, Hirsh, Huang & Yang (2011) present a framework based on Taiwan's cultural perspective. The framework, reproduced below (Figure 2.2), comprises of the foundation formed by clinical competence, communication and ethics; four pillars of humanism, excellence, accountability and altruism; and topped with a beam of integrity.

Ho *et al.* (2011) realised that the framework or model is not complete, leaving various pillars and the roof empty to which other constructs could be added at a later date once a Taiwanese consensus was finalized. Self-dignity and respect (*zizhong*) form the conceptual framework of their model. These two attributes the authors consider paramount to the professional development of a health professional. Integrity represents this beam.

Figure 2.2: National Taiwan University College of Medicine's Framework for Medical Professionalism (Ho *et al.*, 2011 p.1410)

Ho *et al*. (2011) link their framework to the belief system of the Taiwanese and Chinese societies. Their framework presented in Fig. 2.2 is very similar to those presented by Western authors in the past (Ginsburg et al., 2000), except of course with the addition of Integrity as the beam across the pillars supporting further future professional development.

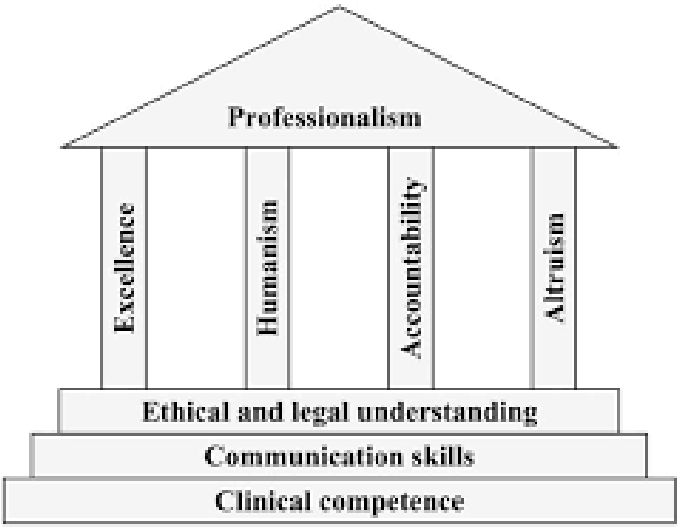


Figure 2.3: The Western Framework for Medical Professionalism (Adapted from Stern, 2006)

Pan, Norris, Liang, Li & Ho (2013) add to the framework of Ho *et al*. (2011) thus (Figure 2.4):

Figure 2.4: Peking Union Medical College's Framework for Medical Professionalism (Ho, Yu, Pan, Norris, Liang, Li & Hirsh, 2014 p.4)

Their additions include teamwork, self-management, health promotion and economic considerations over the beam of morality that replaces integrity in the earlier model.

Nishigori, Harrison, Busari & Dornan (2014) developed a professionalism framework based on the Japanese cultural context basing it heavily on the concepts of *Bushido* (the way of the warrior) as the value system. Bushido connects professionalism to discipline and chivalry, integrity and honour, determination and altruism, all traits exhibited by the Samurai. Their framework is based on seven principles grouped together:

1. Honesty;
2. Benevolence (combining love, sympathy and pity from a Japanese perspective);
3. Politeness;
4. Courage (specifically to the Japanese cultural perspectives, meaning the spirit of bearing and daring, that is, how one carries himself and his self in the face of danger);
5. Honour;
6. Loyalty (placing the needs of individuals and groups above their own as described by the author in context to the Japanese cultural perspective); and
7. Rectitude (representing a way a person thinks, decides, behaves based on reason with an unwavering determination).

Bushido therefore combines the interests of the family and its members, that is, the extended Japanese family as a cultural and socio-political entity.

Al-Rumayyan et al (2017) argue that there is no single framework related to professionalism that can be adopted as a generic, global framework or model of professionalism. They emphasize the importance of developing loco-regional frameworks that are grounded in that area's culture-specific environment, in order to promote the

understanding of, and teaching and learning of, this multi-dimensional and complex culturally oriented construct.

2.7 Professionalism in medical education and training

The Association of American Medical Colleges (AAMC) acknowledged the importance of the teaching of professionalism in 1998 in a Medical School Objectives Project (MSOP) report, *Learning Objectives of Students of Medical Field: Pre-requisites for Medical Schools* that added a series of 'mandatory' statements about the education of the medical students including conduct and behavior (https://www.aamc.org/what-we-do/mission-areas/medical-education/msop). Various support United States organization the statements on professional ethical values and their influence on the humanistic nature of doctors (Doukas, McCullough & Wear, 2012, Doukas *et al.,* 2013). These include the Accreditation Council for Graduate Medical Education (ACGME); the Liaison Committee on Medical Education (LCME); the Joint Commission; the United States Medical Licensing Examination (USMLE); and the National Board of Medical Examiners (NBME).

According to Tallis (2006) in a UK study, if we had paid proper attention to teaching and developing professionalism in the medical field, then the scenario would have been much better. In his study there were many trainees who felt that in medical education, there was now more than ever the need to develop a professional environment and a culture of professionalism. Tallis adds that an educative approach was far preferable to a punitive approach. He argues that there should be time for reflecting on professional values and launching a method of mentoring for students. Roland et al. (2011) summarize that this would help students to learn more from positive role-models and also it would minimize the effects of negative factors and disobliging work environments. Explicitly prioritizing

professional values would have connotations; for student assessment criteria and procedures; for curriculum blueprinting and substance; as well as for postgraduate schooling (Tallis, 2006).

Based on the teachings of Aristotle and arguments presented by Kinghorn (2010), if the highest degree of professional conduct by health professionals is directly dependent on possession of good moral character; and if this moral character (as Greenburg, Durning, Cohen, Cruess & Jackson (2007) continue the argument) is formed in various ways by the time an individual starts training; then it becomes very important to identify individuals with the right aptitude and best moral character at the time of induction into medical school (Stern, Frohna, and Gruppen, 2005). To take it a step further, if students that have been selected on the basis of high moral character are to maintain it and develop further a framework of moral excellence, it becomes necessary that they come into contact with teachers as mentors who themselves exhibit moral excellence (Brater, 2007).

It therefore becomes important to recruit, support, cherish and retain teachers that themselves exhibit clinical and moral excellence (Borrero, McGinnis, McNeil, Frank & Conigliaro, 2008). Kinghorn (2010) argues that if this is not done, every other initiative undertaken to impart professionalism to healthcare education students will most definitely fail. He relates this to the power of the hidden curriculum (pages 46-49). He argues that no matter what is being taught, it will only be reinforced and assimilated if seen in practice. If the hidden curriculum does not support moral and clinical excellence, the same will never be absorbed and practiced by the trainees. The only way to ensure that the hidden curriculum supports best clinical and moral practices is through replacing teachers and other elements that negate the same with those that promote sound professional values (Coulehan, 2005).

Medical educators are quite concerned regarding these issues as they are the ones who feel it is their responsibility to understand and promote professionalism, in turn promoting the production of good professionals in the field of medicine and healthcare. Steinert, Cruess, Cruess & Snell (2005) argue that for effective teaching and evaluation of professionalism, a faculty development program could be designed by medical schools or the government, which could lead to clear changes in teaching and practice and new educational initiatives could be taken based on newly generated ideas. It could help to develop more knowledgeable and skilled faculty members who might become more distinct role models for medical students and other faculty and staff members.

2.8 Summary

In this chapter a scoping review of the literature relevant to the research questions has been provided. The literature available on the subject of medical professionalism is extensive and it was not the purpose of this study to provide a detailed systematic review on the subject. The chapter highlights theoretical and empirical work of some of the scholars that have contributed on this topic. It indicates that there does not exist any consensus on the nature, composition and definition of medical professionalism and the factors that affect not just its understanding but how it manifests itself from one context to the other and from one culture to the other. It is this that we seek to explore in this study. However, the findings and results of this study shall be discussed and interpreted in the light of these and other studies in chapter 4 of this thesis. Next, the methodology adopted for this project is presented in detail in chapter 3 that follows.

Chapter 3 Methodology

3.1. Research Rationale and Relevance

The rationale of this research was to understand the perceptions, the lived experiences and the meaning-making about medical professionalism of a range of stakeholders - doctors, patients, health professions students, healthcare policy providers, nurses and other allied healthcare professionals - across the demographically, economically and socio-culturally divergent province of Punjab in Pakistan. A comparative analysis of differences in the perceptions and meaning-making processes by these various stakeholder groups would help in developing an understanding of how, and the extent to which, cultural differences affect the construct 'medical professionalism'. The literature reviewed suggests that stakeholders are likely to make sense of the term depending on their lived experiences, socio-cultural standing within the community and other demographic variables. Therefore, considerable variation may be found within the same community as well as the same community of practice.

Understanding what meanings these stakeholders develop and also how they develop these meanings will help in educational policy-making within the health professions not just in Punjab but across the globe. Moreover, the findings from this study will go on to inform future researchers as they endeavour to undertake further research in this area.

Research Questions

My research investigated the following research questions:

1. What are the perceptions of doctors, nurses, students, administrators and policymakers in the Punjab, Pakistan, regarding medical professionalism?

2. How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?
3. How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

3.2 My epistemological stance

The views of researchers on the existence and development of knowledge, their epistemological bent in brief, underlie the project of inquiry they conceptualize and run. It permeates every stage of the whole investigation process, from choosing the phenomenon of concern that is put under review to writing the ultimate report. As an educational scholar, I conceive knowledge as being socially constructed and arising from the social practices of peoples; therefore, I conceive social reality as being created and constructed by people, and primarily residing within the minds of people. I agree that the purpose of research is to explore "political and historically situated interpretations of the world of social life" (Crotty, 1998, p. 67).

In order to satisfactorily answer my research questions, I was mindful of the fact that in this research, I would be developing an understanding of how people make sense of the term, 'medical professionalism' through listening to their understanding of their lived experiences (Cresswell, 2013; Flowers, Larkin, & Smith, 2009). I needed a research design that would not reduce what is being investigated to numbers, values, frequency of correlations, sizes and dimensions (Eagly & Riger, 2014). Quantitative research deals with numbers; an ordered system that allows the data to be subjected to rigorous statistical tests of validity and reliability (Carr, 1994). Such numerical data allows for an easy statistical

analysis and the conclusions inferred from this type of analysis can be objective and quantifiable.

On the other hand, Duffy (1987) states that in qualitative research the investigator is able to gather 'rich', first-hand data that is both meaningful and contextual. The so called 'soft' data collected in qualitative research also accounts for the deviant or outlier cases which makes the data richer and it is indeed the outliers that sometimes add invaluable insight to the final analysis (Cormack, 1991). I realized that in order to obtain 'thick' (Geertz, 1973) or rich and descriptive data, my research approach had to be qualitative rather than quantitative.

Crotty (1998) explains that a 'mixed methods' research approach combines methods commonly used in quantitative and qualitative research approaches, seeking the best of both worlds. However, my research questions required exploration of rich qualitative data, an analysis of which would lead to a socially-constructed sense-making and understanding of a phenomenon or a case. Further investigation by exploration of variables through quantitative methods was not the objective of the study and therefore, a mixed methods approach would not have been suitable.

Most importantly, a qualitative research design allows for a constructivist paradigm to be applied. Thus, Adom, Yeboah & Ankrah (2016) state that this approach allows the investigator to construct with the participant a meaning, form or understanding of which is being studied. Understanding is developed in real-life settings. Furthermore, the investigator gleans meaning of events through interactions with other in social and cultural contexts, asserting that reality is subjective since it is formed by the individual perspectives of

participants as interpreted by the researcher in light of his/her own lived experiences (Adom et al., 2016).

In coming to my final decision about the qualitative research approach to be employed in the study, perhaps my most important consideration was the fact that I belonged to a larger community of practice of health professionals, with my own lived experiences within and outside this community which defined my own understanding of 'medical professionalism'. As a researcher I accepted that this understanding that I had developed should as far as possible not influence the sense-making that I was going to develop in this thesis through distilling the understanding and perceptions of stakeholders. In Section 3.8 of this thesis *My Positionality* I discuss the steps I took to achieve this.

Thus, the understanding developed in the study would be as free of personal biases as possible and this would add to the credibility of the research. If I were to interpret data through the lens of my lived experiences, the interpretations would at best have only been helpful in guiding myself and myself alone to a better understanding of the problem. I wanted the results of the study to be as reproducible as possible.

3.3 Choice of research approach

On careful deliberation, it was clear to me from even a cursory look through the list of qualitative approaches that a number of these could be employed to answer one, more or all of my research questions. A mixed method approach was not required in answering them. I will, therefore, very briefly introduce some of these qualitative approaches with reasons for not accepting them as suitable for my research purpose.

Ethnography is the oldest of qualitative research approaches (Strauss & Corbin, 1998; Hoare, 2010) and it is the study of culture. Ethnographic researchers are interested in

identifying how cultural groups function. Data is collected through entering the culture itself using observations and conversations, keeping field notes and reviews of documentary evidence to generate data. This approach could have been employed in my study; however, it would have been neither feasible nor practical. Ideally, I would have had to immerse myself into the culture of various stakeholders, which would have taken a long time. Moreover, the understanding developed would still have been based on my lived experience socially constructed with theirs within their culture, which is something I needed to avoid.

Narrative inquiry suggests a systematic exploration of a series of stories with a specific focus or a set of foci spinning around a three-pronged access of the importance of the story, story-teller and the listener. The researcher is the listener and may be required to align experientially within participants' stories (Clandinin & Connelly, 2000; Behar, Friedman, Pinto, Katz-Leavy & Jones, 2007). This could have been an approach appropriately applied to the study, but for one reason. It is my belief that finding meaning through narrative inquiry of lived experiences of the participants is an extremely complex process, since narratives are never an individual's lived experiences but lie somewhere between idealism and reality.

Phenomenology uncovers the essence of something as it is described, how it functions in the living space as a lived experience. Everything in phenomenology revolves around the lived experiences of the participants about a phenomenon that a researcher wants to explore (Husserl, 1971). Phenomenology is an in-depth study of lived experiences of one or a few individuals that are bounded by the commonality of the phenomenon under study. My research required exploration of the lived experience and gathering perception from various stakeholders across a socially, economically and culturally divergent group of individuals that were bounded by phenomenon that needed to be explored within its real-life context.

Therefore, it could be argued that phenomenology was the research approach that suited my objectives well.

However a phenomenological approach would have required gathering information from hundreds of individuals across a vast region who were experiencing the phenomenon from different socio-cultural, economic and situational/contextual viewpoints. In-depth understanding of each individual sampled from the various stakeholder groups whose perceptions I wanted to gather would not have been possible. Rather, I felt that what was more suited for answering the research questions was developing an understanding of the perspective regarding the phenomenon of the collective rather than the singular within each group.

Case study research is a popular approach to investigating human interests. There are no clear-cut ways of doing case study research (Merriam, 1998). It is up to the researcher to set up a practical and systematic approach for gathering, analysing and presenting information. I felt that my research questions required the exploration of the lived experiences of a divergent group of participants within one geographical and cultural location (Punjab, Pakistan). This required the study of various stakeholder groups distilling into a socially constructed collaborative understanding of a single concept, ′medical professionalism′. Therefore rather than a phenomenological approach, a case study approach suited the research design for this study better in my opinion and the same was employed in this research.

3.4. Understanding Case Study Research

Case study is one of the methodologies used most often in qualitative research. Nonetheless, it still has no valid standing as a technique for study in the social sciences

because it lacks well-defined and well-structured protocols (Yin, 2002). New researchers are generally uncertain about what a case study is and how it can be distinguished from other forms of qualitative research (Merriam, 1998, p. xi).

To help create a roadmap when using case study, I chose to compare three pioneering authors who each provide procedures to be followed when carrying out case study research (Creswell, Hanson, Plano, & Morales, 2007). Stake (1995), Merriam (1998) and Yin (2002) are three foundational case study researchers whose methodological recommendations have had a significant impact on the decisions of educational researchers about case study design.

These three 'manuals' on case study design seem to have different purposes. Stake (1995) is principally addressing students intending to use case study as a technique in their research projects. His main purpose is to clarify a range of interpretive approaches to case study that include "natural, comprehensive, ethnographic, phenomenological and biographical methods of analysis" (Stake, 1995, p. xi).

Merriam sought to add to the case study literature that "remains behind other types of research" (Merriam, 1998, p. 19). The aim of Merriam's book is to explain the ambiguity about case study in qualitative research and to illuminate "what constitutes a case study, how it varies from other methods of qualitative research and when it is best to use it" (Merriam, 1998, p. 19). Yin (2002) maintains that all previous attempts seemed to lack a comprehensive guide on case study process use. Therefore, he wants his text to

> "[fill] a gap in the methodology of social sciences that has been dominated by texts that give few guides on how to start a case study, analyze the data or even minimize the problems of composing the case study report" (Yin, 2002, p. 3).

My initial review of the three viewpoints prompted me to choose a set of criteria to concentrate on to explain the approach that I used in this study. This set of criteria included

the following: epistemological commitments, defining case and case study, designing case study, gathering data, analysing data and validating data.

Epistemological commitments

Yin, Merriam and Stake, as scholars and research methodologists, have their own epistemic responsibilities that affect their perspectives on case study methods and the principles and steps they prescribe to adhere to while using case study method in their research efforts. Stake allocates a large part of his work to the clarification of the epistemological tradition to which he suggests qualitative case study researchers can cling. He thinks that "how case study researchers can relate to the experience of readers depends on their expertise and reality notions" (Stake, 1995, p. 100). He believes that the epistemologies which guide and inform qualitative case study research should be constructivism and existentialism (non-determinism), since "most contemporary qualitative researchers hold that information is constructed rather than discovered" (Stake, 1995, p. 99).

Therefore, he mainly conceives of the qualitative case study researchers as interpreters and collectors of interpretations that allow them to disclose their replication or creation of the constructed reality or information they gather through their analysis. In his view, in addition to this, qualitative researchers would expect another degree of reality or knowledge building to occur on the readers' side of their study. This conclusion is also applicable to his argument that "there are multiple viewpoints or views of the case that need to be reflected, but there is no way of establishing the best view beyond dispute" (Stake, 1995, p. 108).

Merriam seems to be quite close to Stake in terms of her epistemological stance. In her viewpoint, the epistemology that should drive qualitative case study is constructivism, as she insists that

> "the central philosophical premise on which all forms of qualitative research are focused is the belief that reality is created by individuals communicating with their social environments" (Merriam, 1998, p. 6).

She states in the same way "that reality is not an objective entity; instead there are multiple interpretations of reality" (Merriam, 1998, p. 22). Accordingly, in light of this philosophical presumption, the primary interest of qualitative researchers is to understand the meaning or information that people build. In other words, the way that people make sense of their environment and their interactions in this universe is what really intrigues qualitative researchers. Furthermore, Merriam's idea of making sense in the research process is compatible with Stake's multi-layered fact or knowledge-building although she does not require readers to get interested in this construction or analysis. She argues that:

> “The researcher brings a construction of reality to the situation of study which interacts with the constructions or interpretations of the phenomenon being studied by other people. The final product of this type of study is yet another perception of the views of others interpreted through its own by the researcher’’ (Merriam, p. 22, 1998).

Unlike Stake and Merriam, Yin seems to avoid stating assumptions about his epistemic commitments or his preferred epistemology that should guide the methodology of case study. His outlook on case study shows positivistic leanings. Crotty (1998) suggests three ideas are fundamental to positivism: objectivity, validity, and generalizability. If, from Crotty's point of view, researchers say that the results of their proposed analysis would yield "established facts, or at least as similar to established facts as work has allowed to achieve" (1998 p. 41), this would imply that the philosophical paradigm that underlies their research is positivism.

Yin does not specifically express his epistemological orientation in his paper, but the way he approaches case study or analysis in general and the things he discusses most suggest that his philosophical position is towards the positivistic tradition. For example, he states that a case study researcher should “maximize four design quality-related conditions: construct validity, internal validity, external validity and reliability. Whether investigators deal with these aspects of quality control in every phase of case study investigation is highly important” (Yin, 2002, p. 19).

Yin constantly suggests in his text that new researchers should keep these four "yardsticks" in mind in every step of their investigation process so as to ensure its quality. Therefore, a positivistic viewpoint as understood by Crotty underlies Yin’s perspective on case study research. However, Yin's understanding of the relationship between quantitative and qualitative research practices could be reflective of why he would rather not state his philosophical orientation openly. He argues against those who, because of irreconcilable conceptual differences, dichotomise qualitative and quantitative orientations:

> "regardless of whether one prefers qualitative or quantitative analysis, there is a clear and necessary common ground between the two" (Yin 2002, p. 15).

He looks at the commonalities of the two research approaches, and pragmatically stresses the common techniques that can be practical and instrumental in the case study design and methods he proposes.

As I position myself epistemologically very closely to the constructivist model, I consider myself at odds with Yin and much more consonant with Merriam’s and Stake’s philosophical stance.

Definition of a ‘case’:

For Stake (1995), researchers should see case as “a finite structure” and examine it “as an entity rather than a process” (p. 2). He conceives of a ‘case’ as “a particular, complex,

functional object", more precisely "an interconnected structure" which "has boundary and working parts" and is purposeful (in social sciences and human services) (1995 p. 2). Despite this, he argues that the methods he delineates would be more beneficial for studying programs and individuals and less beneficial for studying events and procedures.

Stake lists four distinguishing characteristics of qualitative research that are also true for qualitative case studies: they are 'holistic', 'empirical', 'interpretive' and 'emphatic'. 'Holistic' refers to the interrelationship between the phenomenon and its contexts; 'empirical' means investigators focus the analysis on their field observations; 'interpretive' means that researchers rely on their experience and see research as a essentially researcher-subject relationship consistent with the epistemology of constructivism. Finally, 'empathic' means that, from an emic perspective, researchers represent the vicarious experiences of the subjects.

For Merriam (1998) the delimitation of the 'case' is the defining feature of case study analysis: "the case as an object, a single entity, a unit that has boundaries around it" (p. 27). Her interpretation is in line with the view of case as a finite system by Smith (1978) and as an integrated system by Stake. The 'case' may be an individual, a system, a company, a specific policy and so on, a much more comprehensive list than those of Yin and Stake. In Merriam's opinion, which is inspired by Miles, Huberman, Huberman, & Huberman (1994) interpretation of "the case as a phenomenon of some kind occurring in a confined sense" (cited in Merriam, 1998, p. 27), so long as researchers are able to specify the phenomenon of interest and draw its boundaries or "fence in" what they are going to ask about, they can call it a case.

Merriam conceives of qualitative case study as an "intensive, comprehensive explanation and analysis of a bounded phenomenon such as a system, organization, individual, process, or social unit" (p. xiii). She stresses its distinctive attributes: contextual

(it focuses on a particular situation, occurrence, system or phenomenon); concise (it provides a vivid, thick description of the phenomenon under study); and heuristic (it illuminates the reader's comprehension of the phenomenon under review).

Yin (2002) defines case as “a contemporary phenomenon within its context of real life, especially when the boundaries between a phenomenon and context are not clear, and the researcher has little influence over the phenomenon and context” (p. 13). His description also represents his support for case study as a legitimate research tool. The premise underlying the concept is that other research methods such as history, experiments and surveys are not capable of fully investigating the phenomenon in which researchers are interested. Therefore, they need an utterly novel “comprehensive research strategy” which he names case study (Yin, 2002, p. 14). Thus, case study is an empirical analysis that attempts to answer the "how" or "why" questions relating to the phenomenon of concern.

The rest of his definition focuses on technical aspects of data collection and analysis in relation to the situation under study: to analyse a phenomenon with “many more variables of concern than data points”, case study draws from several lines of evidence for triangulating purposes and takes advantage of “prior development of theoretical proposals for guidance”. This focus is representative of how careful his methodology is in terms of consistency and alignment between the components of the design and phases of case study as a research strategy. From his standpoint, researchers should be able to provide the reasoning while making any step or decision in the research process, in keeping with the theoretical propositions and the characteristics of the case.

In summary, Merriam’s definition is broader than those of Yin and Stake and offers versatility in the use of qualitative case study technique to examine a much wider range of cases. Like Yin's support for case study as a legitimate research technique, as Merriam emphasises its quintessential and idiosyncratic features she seems concerned to help case

study become a well-defined and well-structured research methodology so that new researchers can use it as a research strategy distinct from other qualitative research approaches.

In keeping with the views of Merriam (1998), in this study I endeavour to seek the perceptions stakeholders develop regarding medical professionalism through a process of social interactions with each other within the boundaries of the phenomenon, that is, medical professionalism. These boundaries are dictated by time, place, space, context and culture. I believe that adopting an approach similar to that as described by Merriam will help me understand the meaning that people build regarding the phenomenon in question. Her approach that favours a mutual construction of reality through interaction with each other is at the heart of the constructivist approach that I follow in my research study and one that favours the use of focused group discussions over in-depth interviews.

3.5. Research design

Yin places great importance on case study design: he defines design basically as "the logical sequence that links the empirical data to the initial research questions of a study, and ultimately to its conclusions" (p. 20). He observed that case study does not have a "codified template" as the other social sciences research techniques employ: “unlike other research methods, a systematic ‘catalog’ of case study research designs has yet to be established” (Yin, 2002, p. 19). From his perspective, case study research design consists of five components: the questions of a study; its proposals, if any; its unit(s) of analysis; the reasoning that connects the data to the proposals; and the requirements for interpreting the conclusions. The researcher will ensure, when designing the study, that these elements are aligned to and compatible with each other.

Yin emphasizes the need for researchers to review the relevant literature and include theoretical proposals regarding the case under study before any data collection is started, which distinguishes case study from methodologies such as grounded theory and ethnography. Merriam (1998) provides very insightful and consistent recommendations and guidance on reviewing relevant literature for developing the theoretical framework that will guide the investigation. She describes the method of conducting qualitative research in a rather detailed, step by step manner: reviewing the literature, developing a theoretical framework, defining a research issue, generating and sharpening research questions and selecting the sample.

Unlike Yin, who recommends a really tight and organized case study design, Stake argues in favour of a versatile design that enables researchers to make major changes even after they go from concept to testing. The only initial concept that he suggests concerns the questions and issues that will contribute to the design of the research questions: researchers

> "use issues as conceptual framework to draw attention to ambiguity and contextuality, because issues lead us to examine, even pointing out, the problems of the situation, the contradictory outpourings, the dynamic contexts of human concern" (pp. 16-17).

While considering the design process, I decided it was important to take two factors into account. Firstly, the design process should fit snugly within the research approach adopted, namely case study research. Secondly, the design process needed to accommodate the complexities imposed by the research questions and the setting in which they were situated. I was mindful of the fact that the population consisted of various stakeholders from different communities of practice, as well as individuals from the same community of practice but varying demography. It was necessary to draw out the ‘voice’ of as many communities of practices as possible and from as many contexts across Punjab as possible.

Although a feminist framework was not employed, it was also still important to ensure that the voices were gender-balanced.

Selection of research/data-gathering methods:

Where depth, insight and understanding of particular phenomena are required, interviews and focus groups remain the most common methods employed for data collection in qualitative research (Gill, Stewart, Treasure & Chadwick, 2008). Table 3.1 illustrates the pros and cons of the two techniques. Both can elicit experiences, beliefs and opinions from the study participants using open-ended questioning with inductive probing of responses but

Table 3.1: Focus Group Discussions versus Interviews

	Focus groups	**Interviews**
Appropriate for	• Identifying group norms • Eliciting opinions about group norms • Discovering variety within a population	• Eliciting individual experiences, opinions, feelings • Addressing sensitive topics
Advantages	• Elicits information on a range of norms and opinions in a short time • Group dynamic stimulates conversation, reaction • Rich source of data • Allows respondents to use ideas of others as cues to express their own view • Participants can compare their experiences with others • Able to reach many participants at once	• Elicits in-depth responses, with nuances and contradictions • Gets at interpretive perspective, i.e., the connections and relationships a person sees between particular events, phenomena and beliefs • Gets more in-depth and detailed information about an individual's experiences • Can be useful for sensitive topics • Data can be easier to analyse • Scheduling can be easier
Disadvantages	• Data can be tough to analyse because talking can be in reaction to the comments of other group members • Moderators need to be highly trained and able to lead the group • One strong group member can sway tone of entire group	• It may take longer to collect the data • Limited to one participant's view at a time; no peer comparison • Interviewers need to be trained with excellent one-on-one communication skills • May be more costly (e.g., travel, room rental, transcription fees)

differ in how they are structured (Guest, Namey, Taylor, Eley & McKenna, 2017).

Keeping in view that the study questions required multiple stakeholder groups to be sampled across a vast demographically and socio-economically diverse area (as detailed later in this chapter), I decided to identify the understanding of the phenomenon under study as a collective rather than an individual experience within stakeholders' groups. For that purpose focus group discussions were the ideal tool. It is argued in the literature that focus groups are congruent with a case-study research approach, even being beneficial over individual interviews, since they stimulate discussion, open up new perspectives and allow for a socially constructed meaning to emerge (Guest et al., 2017). This provides a greater understanding of the phenomenon under discussion.

Guest *et al*. (2017) indicate that focus group discussions are based on 6-12 participants and capitalize on group dynamics to stimulate discussion. As a result, groups are believed to provide information through this interpersonal, interactive dialogue that perhaps cannot be gathered through interviews of single respondents separately (Agar & McDonald, 1995). Similarly, Kidd & Parshall (2000) believe that focus group discussions generate a wide range of views and idea that otherwise cannot be gathered through single interviews alone.

On the other hand, Qu & Dumay (2011) argues that interviews offer more insight into an individual's thoughts, feelings and worldview, while focus groups produce relatively superficial data in comparison. It is perhaps this argument that leads, in many cases, to qualitative research designs that combine focus groups with in-depth interviews. This, Potter & Hepburn (2005) argue, allows researchers to initially gather superficial 'surface' data that

can be further explained and individually analysed using in-depth interviews (Nunkoosing, 2005).

The literature generally argues against using focus group discussions in phenomenological research since it argues that phenomenology seeks essential characteristics of a phenomenon in a manner that requires an individual to describe his or her experiences in "uncontaminated" ways (Collins & Nicolson, 2002). This reinforced the decision I had made to take a case study approach rather than a phenomenological approach.

Therefore, the design process aimed to gather data from focus groups of doctors, nurses and other allied health professionals, health professional students, patients and policy makers with 8-15 participants in each group (Creswell. 2013). Focus group discussions were planned to be carried out in various settings across the province of Punjab to meet the requirements of the research questions for a comparative analysis of the sense and the sense-making process of 'medical professionalism' across varying settings (Groenewald, 2004).

3.6. The Participants

Punjab, Pakistan's second largest province by area (205,344 square kilometre) is the most populous province of the country. The estimated population stands at over 110 million as of 2017 (Rashid *et al.,* 2018). The province is one of South Asia's most urbanized with the highest human development index in the country and liberal social attitudes. Punjab is the most industrialized province of Pakistan and also contributes 76% of the annual food grains production in the country. It has the lowest poverty rate in Pakistan.

Apart from Punjabis, people from other provinces of Pakistan also reside there. 75.2% of the population speaks Punjabi, 17.4% Saraiki, 4.5% Urdu, 1.2% Pashto, 0.7% Balochi and 0.1% Sindhi as their mother tongue. This roughly translates into the percentages of ethnic populations in the province. In terms of religion, the provincial population is

97.21% Muslim, 2.3% Christian while Sikhs, Hindus and Parsis make up the rest. As of 2015 the literacy rate stood at 61%. The province therefore is multi-ethnic, multi-cultural and educationally and socio-economically diverse.

As explained in chapter 1, government healthcare has not been able to keep pace with the expanding population over the last seven decades leading to severe shortages of healthcare facilities in both urban and rural areas. 20% of facilities are public and government subsidized. Private care is expensive and mainly centralized in the urban areas. There are 32 private medical colleges spread all over Punjab, each with at least one tertiary care level private hospital of 500 beds.

Merriam (1998) indicates that "purposeful sampling usually takes place before the data is collected, while theoretical sampling is done in conjunction with data collection" (p. 66). In Yin's opinion this suggestion is not appropriate as he insists that case study design should precede data collection. Stake makes no mention of any sampling methods or techniques for qualitative case study research; rather, he avoids specifying an exact starting point for data collection, which he considers to be a function of qualitative practice. In line with the arguments of Merriam, a purposeful sampling technique was adopted in my study as is explained later in the thesis.

When drawing out a sample from such a large area, in this huge and diverse population, I needed to make sure that as wide a range of voices as possible could be heard. In essence I was looking for maximum variability in each focus group of each stakeholder group: variability in terms of gender, age, responsibilities and professional/social status. For cultural diversity I needed to move across the region to gather information from groups from the south, the centre and the north of the province. To maximise socio-economic variability, I also planned to conduct separate focus group discussions for the stakeholders associated with the public and private sectors, by drawing the sample from public and private medical

colleges and their affiliated hospitals Appendix III provides a list of public and private medical colleges in the province: Appendix IV shows where these samples were drawn from in terms of locality within the province). Private institutes are visited by socio-economically well-off individuals who may or may not be educationally advanced as well, whereas public institutions are visited by the lower middle classes and poor who are mostly educationally challenged. Health professionals serving and students studying in private hospitals are generally economically more well-off and have a relatively lower workload as compared to their counterparts in the public sector.

The recruitment process:

The head of each selected institution (nursing schools, medical colleges, polyclinics and others) was requested in writing to facilitate my visit to make necessary arrangements prior to it (Appendix V). It helped that I knew each one of the heads of institutes professionally on account of my position in the university with which their institutions were affiliated. It was advised to make proper local arrangements in the form of availability of a secluded environment, preferably a room with appropriate seating, refreshments and stationery arrangements. A hard copy of a brief, introducing the researcher, the study topic, the rationale of the study, its objectives and any expected benefits was also sent together with the copies of consent forms two weeks prior to the visit. The head of the institution was requested to draw out a list of participants from each group of stakeholders ensuring maximum variability at least three days before the visit and have that list ready together with the signed consent forms. Participants were therefore purposefully selected for these stakeholder groups to have maximum variability within the homogenous groups (Smith & Osborn, 2004) of patients, nurses and other allied health professionals, doctors, health profession students and policymakers. At each institution, the participant list was screened

carefully again to ensure that as much variability as possible in terms of gender, age, experience and status was present before the discussion was started.

I was mindful of the fact that at each institution the head of the institution might purposely nominate participants that in his opinion would respond generally in favour of the institute, its administration, the environment and refrain from saying anything else that the head of the institution did not want to come out into the open. However, all the heads I knew personally and had assured them repeatedly on the telephone that the study would maintain strict anonymity of the participants and their institutions as well as emphasising that the study was generic in nature and the findings would in no way highlight individual institutions or persons. The request for ensuring maximum variability within each stakeholder group was stressed till the reasons were clear to the head and willingness to ensure the same was promised.

Nevertheless it is still possible that at the time of the purposeful sampling, the heads of institutions invited individuals that they believed to hold a certain favourable narrative or opinion, if not regarding the phenomenon, at least about the institution, its performance and the senior administration. This was accepted as the limitation of the study.

The criteria for participation were simple. Participants had to be registered students and/or employees of the institution, either public or private, belonging to that community of practice; patient participants were those who were registered in the out-patient department of that institution. All participants had to be fluent in Urdu, English or both. The participants had to freely volunteer and sign the consent form. In the large majority of focus group discussions, an overwhelming response was received from participants volunteering. However, to avoid dysfunctional focus groups, the number of participants in each focus group discussions was limited to the prescribed format (Guba & Lincoln, 1989; Guba & Lincoln, 1990). Anywhere between 6-15 participants were included in various groups.

The intention of taking a sample from each stakeholder community from various regions of the province was to avoid shallow study and to generate quality and richness through in-depth analysis. At the same time, the number of participants was limited to avoid the researcher being overwhelmed by the sheer volume of the data generated. Paradoxically by increasing the number of participants a study can become shallower (Bentz & Shapiro, 1998). Having participants from different culturally and ethnically diverse regions of the province provided sufficient data to examine similarities and differences from multiple perspectives. This, in turn, added to the trustworthiness of the findings as a form of triangulation of the data (Elliot, Fischer & Rannie, 1999).

The total number of participants in the focus group discussions (FGDs) was 530. Appendix VI shows the breakdown by stakeholder group and the broad region that they were drawn from. It was the pursuit of maximum variability that led to a final tally of 38 focus group discussions. Bryman (2003) argues that a major limitation of qualitative research is the inability of the investigator to limit data collected and thus get overwhelmed by the amount of data collected way beyond the scope of the study. The data collected was indeed overwhelming and it took a long time to complete the process of acquisition, transcription and analysis but the extent and variability of the voices sampled adds strength to this study.

3.7. Data Collection

There were two phases in data collection. The first phase was the development of the FGD protocols, the second was the actual implementation of the focus group discussions.

Development of the protocols:

An extensive literature review yielded a set of pre-determined open-ended questions and prompts (Appendix VII) for the focused group discussions in keeping with the protocols

identified by Krueger & Casey (2009). These included the core question and associated questions related to the central issue (Jamshed, 2014). The set of questions had been formulated based on the review of literature followed by piloting them on a group of five experts. However, some questions were added based on the discussions/discourse during the FGDs whenever there was a need for clarification (DiCicco-Bloom & Crabtree, 2006).

Different sets of questions were developed for different groups, however the objective of each set of questions was the same, that is, for the participants in the FGDs to reflect on their lived experiences and through discussion, dialogue and critical reasoning construct an understanding, a sense of medical professionalism, giving a socially constructed and contextually sensitive meaning to the phenomenon.

Running the Focus Group Discussions:

The researcher serving as facilitator started the FGDs by first obtaining the background information of participants such as their subject specialties. The researcher then followed the following steps (Escalada & Heong, 2011):

1. The objectives of the discussions were explained after briefing about the topic;
2. Participants were requested to give a brief introduction (to give their names and short background information);
3. The whole discussion was structured revolving around the key themes using the probing questions;
4. During the discussion, all participants were given as far as possible equal opportunities to participate;
5. A variety of moderating tactics were used to facilitate the groups.

Each FGD started after explaining the rationale of the study. Written informed consent was again sought from every participant. All participants were informed that participation

was voluntary and that confidentiality would be maintained. It was further explained to them that at any point they could withdraw their participation from the study.

A FGD protocol was used for recording notes during the FGDs (Creswell, 2012). All FGDs were audio-recorded and then transcribed. While transcribing, a verbatim account of all verbal and non-verbal utterances was developed. The participants were given pseudonyms to ensure anonymity.

Except for the patient groups, discussion took place as much as possible in English, this being the language of higher education in the country. However, sometimes Urdu was also used and at times encouraged because some participants were better able to convey their meanings, feelings, beliefs and experiences in Urdu, which is the national language of Pakistan. Focus group discussions involving patients took place in Urdu or sometime even in Punjabi, the most common regional language.

In each stakeholder group, the participants already knew each other and had been working together for some time except in the case of the focus group participants where patients were involved. Conducting FGDs with participants who were already acquainted with each other has multiple advantages. Discussions get on track quickly as introductions are not lengthy and participants find it easier to relate to each other's comments and experiences. They are also able to confirm each other's past experiences as valid (Krueger & Casey, 2009).

For the FGD, I acted as the moderator and also had help from assistants. One assistant helped in arranging the room, distributing refreshments, consent forms, information materials, seating participants at the designated places, debriefing with the moderator and most importantly operating the recording equipment. Another assistant moderator was wholly responsible for note taking.

Addressing Groupthink:

While the strengths of having participants in the focused groups that knew each other for some time and had been working together have already been mentioned earlier, there is a documented demerit as well. The discussion can follow a pattern of thinking that may be adopted by these cohesive group members who are bound together with an association of shared lived experiences within the same environment (Janis, 1982). This phenomenon is known as groupthink and some regard it as a myth (Fuller & Aldag, 1998). Nevertheless, the possibility that groupthink might affect the data collected had to be pre-empted and safeguarded against.

This was mitigated through encouraging critically effective dialogue. Questioning techniques that challenged any potential groupthink were employed in the FGDs (de Groot, Endedijk, Jaarsma, Van Beukelen& Simmons, 2013). Interactions amongst participants were encouraged and they were asked to question each other, serving to build on comments and confirm or disconfirm feelings and experiences that had been shared (Linville, Lambert-Shute, Fruhauf & Piercy, 2003).

Transcription:

For transcription, participants were assigned pseudonyms to protect their identities. The alphanumeric pseudonyms scheme followed the following protocol: the first two letters give the stakeholder group:

FC – Faculty
PM – Policy Maker
MS – Medical Student
AH – Allied Health Sciences Student
PT – Patient
NR – Nurse

The third letter gives the institution, names of which are not disclosed. The fourth letter gives the gender: M=male, F=female. The final number gives the designated number of participant included in the group.

Where English was not used, I translated the Urdu or Punjabi text to English. At the time of member-checking, these translations were specifically confirmed to ensure the meaning as intended by the participant was as much as possible transformed over in the translation.

Member checking - informant feedback on transcriptions - was used as a technique to help improve the accuracy, credibility, validity and transferability of the study (see Section 3.10 below). This was accomplished in all cases except in the case of patients, where it was difficult to locate them again after transcription since they travelled back to their local villages/hamlets and were largely unreachable. For other groups, transcriptions were sent back to the group as a whole at a later date and feedback from the group as a whole individuals was received on a copy of the transcript. Any afterthoughts added later on by a participant were generally not accepted since they were not part of the discussion. Only the content of the discussion transcribed was validated through member-checking.

As part of the iterative process that had to be maintained throughout the entire course of the study and to maintain reflexivity (as discussed below in Section 3.8), reflexive notes were made after each FGD, at regular intervals throughout the research process, in my reflective journal. I was careful to refer back to my notes at the end of the discussion or at intervals and clarify any concept of the discussion that I needed to be sure about. This technique was employed for all groups but most extensively for the groups containing patients.

3.8 My Positionality

Having adopted a qualitative case study approach (Yazan, 2015), I felt that it was necessary in my study that the personal baggage of preconceptions, theories, hypotheses, interpretations of personal lived experiences related to the phenomenon under study were left under suspension and the rich data of participants' sense-making of their lived experiences and understanding of the phenomenon was received and interpreted by the researcher as far as possible without personal bias (Kirby & McKenna, 1989; Finlay, 2011; Tufford & Newman, 2012). I was aware that my positioning in my research could not be fully objective but could be reflexive (Reid, Flowers & Larkin, 2005; Koch & Harrington, 1998).

Reflexivity is a process by which we continuously question ourselves, our interpretations and our understandings, our values and belief systems; being aware of any biases, prejudices and preconceptions that may be influencing our understanding. It is a process of internal dialogue (Archer & Archer, 2003, p. 103). Through this process of internal dialogue with myself throughout this study, I was able to maintain a degree of objectivity by ensuring that my personal beliefs, values and understandings remained suspended as per the requirements of bracketing. This permitted an open gaze to be projected towards the phenomenon under question. By employing reflexivity, I was able to use the same sense-making strategies as the participants, applying them systematically and consciously. This way I was able to minimize taken-for-granted assumptions and over-interpretations.

This required me to be consciously critical of myself, my position, place and status within the group, the community and the community of practice. This was helpful at all stages of the study including the focus group discussions and the interpretation of data (Shaw, 2010). By keeping a reflexive log (Appendix VIII), I was able to gain critical self-awareness of my own positionality and the limitations of my perspectives (Brookfield, 2009). This

reflexive process was thus able to add further transparency to this study (Lopez & Willis, 2004; Shelton, Smith & Mort, 2014; Subedi, 2006; Yardley, 2008).

I realized that it was important for myself to remain as much as possible distanced from the research participants in order to successfully detach and separate myself from their experiences. This process is termed "bracketing" (Finlay, 2011; Tufford & Newman, 2012) and helps researchers mitigate the influence of and even suspend their perceptions, experiences, values and emotions during a study. I needed to 'bracket' myself, thus remaining on the periphery and by no means relating my lived experiences with theirs – especially during discussions. If I were not to do this, then my personal biases and prejudices would influence my sense-making of their accounts of their lived experiences as they related them to me. Secondly, if this was the path I was going to take, a path in which my own personal understandings and perceptions were to be suspended in the sense-making process, I had to ensure that the process of reflexivity employed throughout this study to provide trustworthiness (Denzin, 1997; Guba & Lincoln, 1989; Morrow, 2005) was extended into the interpretation of participants' data, so that this interpretation was not seen through the lens of my own lived experiences.

Whereas Cresswell (2013) argues that whatever is researched should always be filtered through the researcher's own positioning and values, 'bracketing' required that I should attempt to suspend my positioning and values during the course of the study. This proved to be an ideal methodology for the analysis of the data collected in this research. As was required, suspending my social, economic, political and religious views, preconceptions and ideations allowed me to sift through the data with a blank yet open mind as much devoid of individual prejudices as possible.

Bracketing proved to be quite challenging, given my long history of service within the healthcare industry and long-standing interactions with health professionals of all types, ages and genders (Cohen, Manion & Morrison, 2011). I was able to maintain this outsider stance while still belonging to the same community of practice and being an insider bringing out my values and positioning at every step of the research study right from the conceptualisation of the study to drawing up the conclusions and recommendations and being consciously aware of them; thus consciously suspending them throughout the course of the study (Pope, Ziebland & Mays, 2000). I found that maintaining a reflexive journal helped me at every stage of the analysis, not just keeping me on track but also ensuring that bracketing was successfully maintained throughout the process.

3.9 Data analysis

Stake's (1995) views on analyzing data are consistent with those in data collection. He capitalizes on the experiences of researchers as the primary source of data and as the study makes sense of them. While he supports the use of analytical protocols "that help [researchers] systematically draw from previous knowledge and minimize misperception," he gives precedence to intuition and interpretation rather than protocol guidance (Stake, 1995, p. 72).As a standard theme in qualitative practice, he indicates that researchers are to perform parallel processes of data collection and analysis. Furthermore, there is no exact point in starting study in the research process as there is no exact point for starting data collection.

Stake identifies two systematic methods of analyzing data: categorical analysis and direct interpretation, which he introduces as two common techniques for managing the data from case studies. He then introduces specific techniques to identify the trends that are an essential part of the two overall approaches. Nevertheless, he admits that these methods are

not the best way to conduct case study analysis, and adds that "Every researcher needs to find modes of analysis that function for him or her through experience and reflection" (Stake, 1995, p. 77).

Merriam describes data analysis as "the method by which the data make sense. So making sense out of the data means consolidating, minimizing so explaining what people have said and what the researcher has seen and heard–it's the process of making meaning "(Merriam, 1998, p.178). Compared to Stake's concept that emphasizes the perception and experience of researchers in study, Merriam's definition of qualitative data analysis tends to be a more rigorous implementation of constructivist epistemology in science and provides the researchers with more specific guidance. Consolidation, reduction, and interpretation contribute more than perception and intuition to a simple and concrete implementation of constructivism in analytical method.

Second, Merriam discusses the simultaneous compilation and analysis of data, which Stake briefly addresses. She devotes one part of the chapter to describing why and how simultaneously data can / should be obtained and analysed. She also emphasizes that this is a quintessential characteristic of qualitative research design that separates it from the positivistic epistemology-oriented research. However, she makes a caveat: promoting a continuous and complex data collection and analysis "is not to claim that the research is done when all the data are obtained. Quite the opposite. Research is intensifying as the research continues, and once all the data is in "(Merriam, 1998, p. 155). This concurrent and collaborative approach stems from the fact that an evolving concept is promoted by qualitative methodologists. Preliminary data analysis may result in alterations in the subsequent research phases.

The task in this study was daunting since the analysis of 38 focus group discussions had to be done. Yet an iterative process was maintained along with the analysis and the entire data was read once, twice and then a third time. Each time, emerging themes were identified, reviewed and improved upon during the iterative process until finally a refined emerging theme or code was plucked out of this enormous pool of data and carefully adjusted along other emerging themes. The following steps of thematic analysis, as advised by Braun, Clarke, Hayfield, & Terry, (2019) were followed.

3.9.1 Familiarizing with data

As advised by Bird (2005), the audio-recordings of the focus group discussions were listened to carefully and transcribed manually, maintaining focus on accuracy and being vigilant to changing tones and emotions. Where English as a language was not used, translations were done that conveyed the meaning meant in the other language. In place of English, mostly Urdu was used or Punjabi. Only in a few instances, participants (some patients only) spoke in Saraiki, a regional dialect of the south Punjab. Where necessary explanatory notes were needed, the same were recorded on the side of the transcribed text. Analysis continued along with focus group discussions and translations. However, each was done on separate days, so as not to allow one to influence the others. While doing the analysis an audit trail was maintained of each step. As already stated, descriptive, linguistic and conceptual components were highlighted, in that, a record of figures of speech, emotional responses, metaphors and specific use of language was carefully maintained along the passages and paragraphs.

Through an iterative process of reading the transcripts and listening to the recordings again and again, immersion in the data was achieved. Thus, various patterns in text and

recording were identified. A thorough reading of all the interviews was done, before I started to code the data. The data gathered from the thirty-eight focus group discussions was vast and the iterative process required going through the data again and again. It is pertinent to mention here, that the data from each of the six stakeholder groups was analysed separately. Thus, through this process the initial codes emerged from the data.

3.9.2 Generating Initial Codes

The iterative process of reading, re-reading and listening to the transcripts continued till codes were identified in all the focus group discussions belonging to one specific stakeholder's group. The recordings were listened over to, time and again while reading the data to ensure that any meaning inferred through tone and phrases was clearly associated with the words spoken. Miles, Huberman, Huberman, & Huberman (1994) suggest that the process of coding is part of the analysis as this leads to organization of data into meaningful groups. Tuckett (2005) argues that coded data differs from themes, in that, themes are broader. In the next phase of the analysis, during the development of themes, interpretative analysis of the data was carried out. The reflexive process of repeatedly reading and listening to the data helped ensuring that, all possible codes were identified. To reflect on what respondents said and why they said it added meaning to the codes that was essential before the next phase in the analysis.

3.9.3 Searching for Themes

The themes emerged from grouping the codes together and linking meaning to these groups. At the same time the reflexive practice of reflecting on who said what, why and in what context was continued as the data was read and listened to again and again so as to ensure that the groups of codes were as close to the meaning being transferred as possible. A rough thematic map of this early stage of collating the codes was manually developed. Initially the codes were grouped into sub-themes and similar subthemes were then grouped together to form broader themes (subordinate themes). No code or sub-theme was discarded. Rather, through a process that involved reflexivity and iteration, the thematic map was reviewed and realigned to best represent the reality as interpreted to be transferred through the data collected.

3.9.4 Reviewing Themes

Themes thus identified were refined through yet another round of reading, re-reading and listening to the recordings of the focus group discussions while critically analysis the codes, sub-themes and themes in order to ensure that the fullest, most accurate meaning from the data was transferred on to the final themes. Special attention was given to codes that were few or marginal or themes that did not fit with other themes, such codes and subthemes were not discarded but carried forward individually because for the researcher sense-making and data analysis was not quantitative rather qualitative in nature. Since, while it was important to ensure coherence in pattern, it was equally important not to discard even the simple code of significance.

3.9.5 Defining and naming themes

This phase of the thematic analysis followed the development of a satisfactory thematic map from the previously reported exercise. In this phase again the entire thematic map was reviewed while the transcripts, the notes, the codes and subthemes were re-visited and the audio-recording were listened to gain. The essence of each sub-theme and theme was questioned and if required the theme and subthemes were further refined. Each theme was required to represent particular, significant idea, path, trail or story so as to say, in the light of research questions of study. Each theme was also evaluated on how it connects with other themes in relation to the research questions. Finally, each theme could be clearly defined at the end of this phase.

3.9.6 Producing the Report:

In this stage, a full analysis and write up of the themes and the meanings they conveyed, how they were brought forward from the data in the form of subthemes and what did the codes represent was undertaken. The task of the thematic analysis is to present the full comprehensive account of the story presented in the data. It is required to be logical, coherent, non-repetitive and an interesting account of the story. Care was taken to support all claims with evidence from the literature and to build up on argument of the interpretation in light of the evidence available currently, in literature. This required quoting accurate and vivid examples of extracts from the data to support each theme and its interpretation.

Appendix IX provides comparison of case study approach by the three authors discussed above.

3.10. Ensuring quality and rigour

Cresswell (2013) argues that the assessment criteria applied to quantitative research (validity, reliability, generalizability and objectivity) cannot be applied to qualitative research methodologies. Morse (2010) argues that quantitative and qualitative research traditions represent very different paradigms. Each is underpinned by its unique theoretical and methodological perspective (St. Pierre, 2006; Yardley, 2008). Guba & Lincoln (1989) developed a set of criteria for assessing the quality of qualitative research that draws parallels with those of quantitative research. Their criteria included credibility, transferability, dependability and confirmability.

However, there is not one accepted test of rigour in qualitative research because of different ways of doing qualitative research. Constructivism puts forward the idea that there are multiple versions of reality as it is the result of a construction between "knower" and "seen." Merriam states,

> "One of the principles underlying qualitative research is that nature is complex, multidimensional, and ever-changing; it's not a single, set, empirical phenomenon waiting to be discovered, observed, and evaluated as in quantitative research" (1998, p. 202).

Merriam (1998) and Stake (1995) are both aware of the fact that the principles of truth and reliability are almost impossible to apply to qualitative inquiry since they were first created within a positivistic tradition. It is not possible to implement these initially positivistic ideas into a qualitative research that is guided by constructivist epistemology. Hence the conceptualization of truth and reliability by Merriam and Stake varies considerably from that of Yin (2002).

Emden & Sandelowski (1998; 1999) introduced the concept of goodness, rejecting more stringent and structured thinking in the postmodern era allowing qualitative researchers

to use the most appropriate means of assessing rigour which reflect the methodological assumptions of the project. Carter, Bryant-Lukosius, DiCenso, Blythe & Neville (2014) brought in the concept of triangulation as a claim to 'truth'. In the end, the best set of criteria for assessing the worth of the qualitative research are those that fit with the assumptions of a specific methodology, in this instance case study research.

Sandelowski (1986) suggested the criteria of credibility, fittingness, auditability and confirmability and it is against these four guiding principles of quality and trustworthiness that I shall justify my analysis in the following discussion.

Credibility:

Out of the four criteria established for trustworthiness, credibility is the most important criterion. Credibility asks the researcher to establish that the results of the research are believable from the perspective of the participants in the research. There are various techniques to establish credibility in qualitative research. All of them cannot be employed in every study. As previously stated each qualitative methodological paradigm is based on its own theoretical perspective and randomly applying every technique and criterion of trustworthiness would be both uncouth as well as counter-productive (Trainor & Graue, 2014). The two techniques that were employed in my research to establish credibility were *member-checking* and *triangulation*.

Member-checking, as a technique to establish credibility in qualitative research (Angen, 2000), was employed at three levels in the study. Firstly, the transcripts of the audio recordings of the participants (except for the patients) were shared with them within 24-48 hours of the focus group discussions together with the audio recording. The participants were asked to confirm that their comments had been correctly transcribed and especially in the case of translations of words, jargon and sentences where true meanings were correctly

captured. Secondly, at the time of interpreting the data, the interpretations drawn from the transcribed data were shared with the participants to confirm that their true meaning and sense had been captured. Finally, at the time of drawing conclusions from the analysis of the data the participants were again asked to clarify if the true essence of their understanding was captured in the conclusion. The participants could provide additional information, if required.

Triangulation involves using multiple methods, theories, observers or data sources in the study. This allows the researcher to gain a more complete understanding of the phenomenon being studied. It adds to the robustness and richness of the research findings and ensures that the data is comprehensive and well developed. Stake (1995) provides four methods to triangulate evidence: triangulation of the data source, triangulation of the investigator, triangulation of theory and methodological triangulation. Out of these four techniques used in triangulation, only three were applied in my study.

Methodological triangulation involves different data collection techniques to be employed in the study in order to check the consistency of the findings. In my study, the findings are based on data collected through two methods, literature review and FGDs. As already detailed earlier, robustness in both techniques was maintained through following standard protocols. *Triangulation of data sources* involves utilizing different data sources within the same method. Four different stakeholder populations were used. Multiple FGDs were held in both public and private settings across a demographically divergent region. In order to add trustworthiness to the analysis of the data, a colleague with a Master's degree in Health Professions Education was asked to also analyse the data-set. His analysis in comparison with mine was very helpful in illuminating 'blind spots' in the analytic process. *Investigator triangulation* was, therefore, employed in the study.

Fittingness:

Fittingness is also called transferability of research findings and refers to the study findings being transferable or in other words fitting outside that particular study. In other words, it refers to the ability of the researcher to demonstrate in the study that his findings can be applied to another context or another group (Byrne, 2001). In this study transferability was demonstrated through an accurate and rich description of research findings and by providing adequate information for evaluating the analysis of data. Transferability should not be confused with the quantitative research assessment criterion generalizability, because from a qualitative perspective, transferability is primarily the responsibility of the one doing the generalizing. The job of the researcher is to provide the evidence that the findings can be transferred to another group or setting.

In my study, evidence for fittingness was provided by keeping a detailed log of the entire data collection process together with a thick description of the participants, setting of the FGDs, detailed description of the environment, social context and cultural settings in order to help provide the reader with a richer and fuller understanding of the research setting (Rodham, Fox & Doran, 2015). Some examples of cultural sensitivities adhered to and thick descriptions maintained of the same included scheduling FGD between prayers, giving prayer breaks if the FGD fell around prayer timings and arranging gender-based seating in the rooms where FGDs were held.

Auditability:

Auditability in the study was maintained by keeping a rich description of every step of the study in a research journal. The journal contained personal experiences and motivations that led to the choice of the research question; the rationale and the purpose of conducting the study; the way it was conducted; the reasons for the choice of the research methods; rich

details of FGDs; interpretations and analysis; and conclusions drawn referring at each step to personal lived experiences and drawing out personal biases and preconceptions so that they could be consciously suspended. By providing an audit trail, it is possible for a reader to follow the thought process and rationale applied at every step of the study (Yardley, 2008).

Confirmability:

Confirmability refers to the degree to which the results of the study can be corroborated by others. Simply stated, would other researchers asking the same questions in the same settings and contexts, using the same methodology, reach to the same conclusions (Guba & Lincoln, 1989)? Theoretically, confirmability is a concept that can perhaps never be fully materialized. This is because one of the basic assumptions of qualitative research is that each researcher brings his own perspective, values, belief systems and personality to the research, which affects the interpretations, sense-making and findings. Stake states:

> "most qualitative researchers believe that there are not only multiple interpretations or views of the case that need to be reflected, but that there is no way of establishing the best view, beyond disagreement" (1995 p. 108).

Therefore, one of the reasons for choosing a constructivist and qualitative approach was to lay down my personal beliefs, values, pre-conceived ideas and perceptions explicitly for my awareness and that of the reader and to document every step of the research study in a reflexive journal following an iterative process throughout the study. By being more aware of my beliefs and perceptions, I was more consciously able to suspend them and document the same in the reflexive journal (Yardley, 2008). Another researcher, by following the same steps, under the same settings, therefore would be likely to come to similar but not identical conclusions.

3.11. Ethical Considerations

In any research study, the rights and interests of the participants/subjects of the study need to be protected. The research process should be honest and fair (Morse, 2015). Ethical approval for the study was sought from the University of Health Sciences, Lahore, where I was employed during the study. The University of Health Sciences has a standing committee on ethics called the Ethical Review Committee. Approval from the Ethical Review Committee was received following a detailed presentation to the committee regarding the entire research study including the rationale and purpose of the study, objectives, research questions, the methodological framework for data acquisition and data analysis and the outcome of the study (Appendix X-XII). Detailed explanations were provided to the committee regarding the content, nature and mode of consent to be sought from the participants. Approval of the consent form was also given by the committee. Subsequently, a similar presentation was also given to the Advanced Studies and Research Board, a statutory body of the University of Health Sciences that reviews and critiques research proposals and grants approval to the University-supervised studies.

Ethical considerations were safeguarded throughout the research process. As explained earlier, written informed consent was obtained from the participants through providing an information sheet detailing the purpose and nature of the study, the responsibilities of the researcher and expectations from the participants and the rights of the participants. Information was also provided on how the data would be gathered, secured and presented. At the time of the FGDs, the consent was reaffirmed verbally both in English and in Urdu, the national language. The participants were encouraged to ask questions and were informed that they could leave the study at any stage of the research as a right and without prejudice.

The audio-recordings and the hand-written notes of the FGDs were secured in a separate locker in the office of the researcher, while the transcriptions from the audio-recordings and documents received after member checking were secured in another office of the researcher together with data analysis sheets and thesis drafts. All electronic files were password-protected and stored in the office computer of the researcher. Backup was maintained in the password-protected hard drive kept in the safe locker with the audio-recordings.

During FGDs, cultural and gender sensitivities were safeguarded in accordance with Islamic principles applicable to time and space. Gender-specific seating arrangements were made. Women were addressed politely, assigning the suffix “madam” to their first name. Considerations for prayer timings were maintained throughout all FGDs. Contact details of the participants were kept in written and electronic formats by the researcher himself in a separate locked drawer and were not kept with the paper copies of the transcripts.

3.12 Summary

In this chapter, I have explained the rationale for my study and the choice of methodological framework with justification for how the methods chosen were suitable to the research questions being asked. I have described the study design and how quality and rigour were established and ethical considerations were maintained. In the next chapter, the findings shall be provided.

Chapter 4 Findings in Relation to Research Questions 1 and 2

4.1. Introduction

This chapter deals with the analysis of the data gathered from the focus group discussions. The analysis was set against the backdrop of the following research questions:

1. What are the perceptions of doctors, nurses, students, administrators and policymakers in Punjab, Pakistan, regarding medical professionalism?
2. How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?
3. How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

At the 38 focus group discussions (FGDs) that lasted from 45 to 180 minutes each, patients, medical students, allied health sciences students, policymakers, doctors and nurses discussed their understanding and perceptions of the term 'medical professionalism' and the factors that affect it within their own stakeholder groups. 530 participants were included across the entire stakeholder groups of varying genders, ages and demographic backgrounds. Their discussions were based on their unique experiences of the phenomenon 'medical professionalism' and the perspectives they had developed within their life-worlds. These findings attempt to make sense of the multitude of inputs related to the phenomenon provided by the participants of the study.

4.2. Structure of the presentation of findings

Four distinct themes were developed following a thematic analysis of the FGDs. These were: VALUES-DRIVEN, ADEPT, POTENT LEADER, & SUPPORTED. These are presented in Figure 4.1. These four superordinate or master themes were common to all

stakeholder groups, although similarities and differences were noted as to how these themes emerged out of the analysis of contributions to the FGDs by the six stakeholder groups.

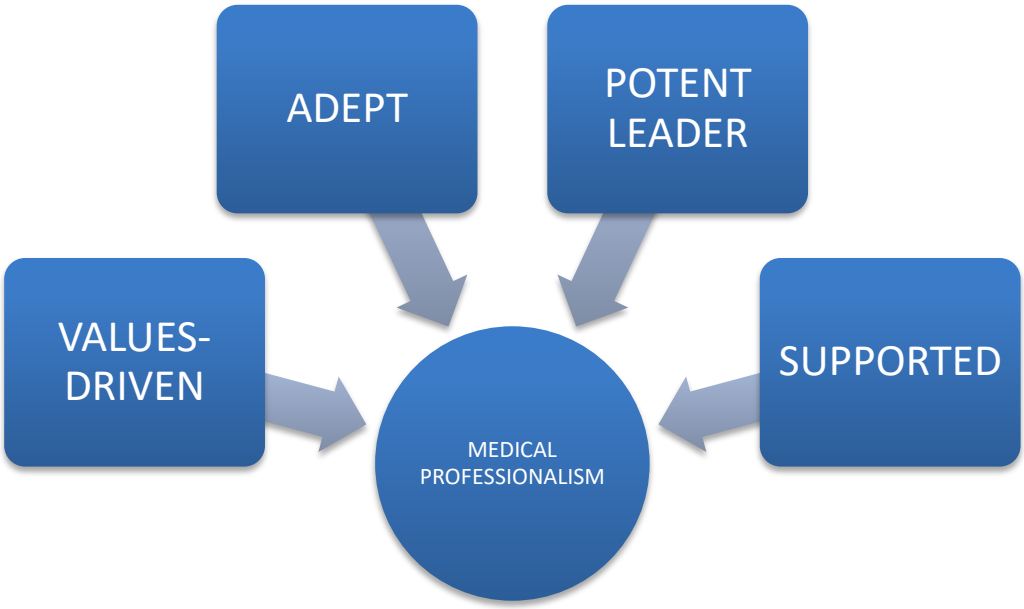


Figure 4.1: Master/ Superordinate Themes

The subordinate themes are presented in Figure 4.2. They represent key elements of the sense-making of the participants regarding the phenomenon of 'medical professionalism' encapsulating both epistemological and ontological dimensions (Tomkins & Eatough, 2013). Figure 4.2 provides a basic visual representation of how the participants understand this phenomenon. I shall discuss findings in response to my research questions, particularly RQ1. I will conclude with a summary of findings from the focus group discussions.

4.3. Theme 1: VALUES-DRIVEN

> *"There should be an aptitude test before admission into medical colleges. Those that are identified as individuals who want to enter the profession to serve humanity and already possess the basic value system from which professionalism is derived ought to be selected." (MSDM8)*

Branch (2010) in a US study on how physicians draw satisfaction and overcome barriers in their practices reports that one's value system plays a key role in the development of professional identity. Holden *et al.* (2015) support the role that this personal value system plays in the development of this identity. In my study *Values-Driven* emerged as a master or superordinate theme with the following three subordinate themes:

1. *SPIRITUAL*
2. *MORAL*
3. *HUMANE*

Figure 4.2: The path to Medical Professionalism

4.3.1. Subordinate Theme: *SPIRITUAL*

> *"Allah almighty is watching us and our attitude towards everyone, and we are responsible for our deeds. If we don't behave well, our goal for betterment of society cannot be achieved." (NREF2)*

> *"If no one else is watching us…we as Muslims believe that Allah is watching us always and all our deeds are being recorded and for wrong-doers there will be punishment from Allah in the form of illness and disease." (MSJF4)*

> *"Religion does influence our behaviour and so does culture. What we do depends on a mixture of cultural and religious norms and practices and rites and stuff like that." (MSCF11)*

Medicine today is a secular profession for some, while for others the practice of medicine still holds significant religious connotations. The relationship between religion and the practice of medicine is as ancient as time itself. Harris, Sillence & Briggs (2011) report that Maimonides (1125-1204) was a scholar of the Torah and a physician: his Oath states: "the eternal providence has appointed me to watch over the life and health of Thy creatures". They add that religious leaders also practiced the art and craft of medicine in olden times and in fact this practice has not changed in some parts of the world even today.

The connection between the doctor and the divine was frequently referred to by various participants of the focus group discussions in all stakeholder groups and was based on the following attributes: God-fearing, belief in the divine, religious beliefs and the religious-life balance.

The subtheme will now be further explored in terms of three components which were identified: religion as the source of moral/professional values; belief in divine healing; and belief in divine retribution.

Religion as the source of moral/professional values:

In my study spirituality, belief in the Divine and fear of the Divine emerged as important attributes which define medical professionalism, as exemplified below in the quote derived from focus group discussions with policy makers:

> *"I have found that those doctors that are deeply spiritual, regardless of religion, are better and more professional doctors." (MSAM3)*

One respondent linked religion and religious beliefs to professionalism thus:

> *"We are taught in childhood, taught Holy Quran that what is right or wrong. So we can do that is right or wrong." (FCFM5)*

A medical student explained the religion-professionalism link as:

> *"Sir, religion has role because it makes obligation to speak nicely, it is part and parcel. As a Muslim we say we should behave in good manners while dealing [with] the patients. We have to be good, cool and impressive. Our religion has complete code of conduct, if we are good Muslim we will be good doctor also." (MSAF2)*

Another participant responded to the debate with the following quote that lays emphasis on the basic premise of religion as an institution that sets the morality right of its followers,

> *"I think it is very basic thing because as we said in professionalism it is religious based and where you are living. Quran insist[s] on that as described in Quran that "Every person has been born with the sense of right and wrong". Human beings belonging to any nation, any religion, know about what is right or wrong, that is one thing." (FCFM8)*

A distinction has to be made here between religion as a set of abstract values and a set of rules guiding actions and behaviours. It is in reference to the latter idea that we find discussion in all focus groups. An extract from discussions with nurses and policymakers sheds further light on this attribute:

> *"Our religious beliefs define us. They define our actions and our motives." (PMAM1)*

> *"But every religion whether it is Islam or Christianity all has a very broad vision." (NRFF3)*

The belief in the service of humanity was also identified as an important aspect of professionalism in all stakeholder focus group discussions:

> *"I think our religion….any religion teaches us to serve our fellow human beings the best we can." (PMCM3)*

> *"Every religion has one main thing, that is, humanity. Every religion is based on humanity; it revolves around its surrounding that you have to serve the humanity. No one is allowed to murder…" (NRFF2)*

The MBBS student stakeholder group in relation to inclination towards service to humanity went so far as to say:

> *"Our religion and profession are interlinked. Deeds are backed by thoughts." (MSGF6)*

But the following respondent goes on to caution on religion-life balance:

> *"There is my colleague on rotation working with me at the closure of surgery time and he says it's my prayer time. What should I say? He himself is doing other different wrong things and on [official] enquiry [for unprofessional behaviour]. But prayers he refuses to miss while patients' emergency care he is willing to neglect for his prayers" (FCEM11)*

Maintaining a healthy balance between religion and life was considered important by a majority of the respondents. Yet there were outlier quotes that separated religion, culture and professionalism:

> *"The environment we live in, the people we live with and the culture teaches this. It is a dilemma in Pakistan that we drag religion in every matter. We don't follow our religion but we drag it. Religion tells us good things. Professionalism is a totally different thing. It is not linked with religion. Religion fortifies it, supports it but has no connection. In none of our medical books it is mentioned that your religion teaches you this. Quality service on merit at its very prime time is professionalism." (FCHM1)*

Denouncing any link of professionalism with religion, one faculty member stated:

> *"There are many a people who do not believe in God, neither they believe in the Prophet (PBUH) but they are highly professional. Professionalism has no link with religion and ethics. It is an attitude. If you cater [to] this attitude, you are professional otherwise you are not."(FCHM3)*

Another respondent had the following to add to the debate:

> *"We expect from doctors to set aside their religious beliefs and concentrate on doing good for the patient regardless of religion or sect." (PMBF1)*

This conflict between religion and science is not new. Following the French Revolution and after Descartes, it was said that the body belongs to the physician and the soul to the priest. Nevertheless, there is overwhelming evidence in the literature, especially that from the United States of America, as well as coming out of this research study that the stakeholders identify religion and religious beliefs, as well as the physicians' and the caregivers' belief in them, as desirable traits of medical professionalism. Mixing religion and profession may be desirable as is evidenced from the following quotes extracted from focus group discussions involving physicians:

> *"When we segregate religion and the world, it poses problems. To live life according to the principles of religion is religion actually. It is way of life. The religion is to fuse our culture and our way of living with moral values. Religion greatly influences setting standards of a society. Like religion varies in abortion laws. So, we must not make a mistake of segregating 'religion' from 'world'."(FCHF11)*

> *"Religion makes you better caregiver and you give positive response." (FCKM10)*

And yet…. one is also cautioned:

> *"Religion also affects the behaviour, but we don't have the proper religious knowledge and the people who deliver religious knowledge are under school certificates [qualified]. We are not fair with our religion." (MSGM7)*

> *"Just having knowledge of religion is not enough. The most important thing is execution, we all have the religious knowledge but we don't implement it. With implementation we can improve professionalism." (MSGF8)*

The current study identifies religion, any religion, as the provider of basic ethical values and norms; rules and laws that act as guiding principles for the discharge of medical professional duties and social interactions by caregivers. At the same time, it draws our attention towards religious flexibility allowing us to constantly monitor our actions and

interactions in the light of the religion and to question them based on the evidence available in literature and from scholars.

A Belief in Divine Healing:

Welch (2003) proposes that modern medicine techniques are very similar to the techniques used by the priests and spiritual leaders. Both try to make the experience of healthcare feel supernatural and out of this world. Patients, he argues, are left feeling that the power of belief in the healing process is equally as important to the healing process as the drugs and interventions.

Bărbulescu (2011) in her study identifies that health and illness are closely linked to the supernatural, even in certain European communities like the one in their study in modern times in Transylvania. She writes,

> "… in the peasant communities studied, illness is not only a breaking of the physiological equilibrium of the body, but also a punishment for some faults committed against beings with supernatural powers or the result of some hostile magic actions." (p.550)

Day, Silva & Monroe (2014) argue that an attempt at healing is understood by the indigenous people of the Americas even to the present day as a restoration of balance, a sacred act on behalf of oneself, one's family, one's community, one's homeland, and the larger universe. Physicians and the priests were one and the same and it was only later when the scientific revolution set in that the two professions diverged and that too only in some cultures. Similarly, in South Africa up till 1994, the spiritual leader, spiritual healer, the priest and the healer were one and the same and these terms identified a singular entity, that is, healer priest (Louw & Duvenhage, 2017). Louw & Duvenhage (2017) conclude that

> "it is clear that the traditional healers' training, practices and treatments have been erroneously construed as medical over many years, while these practitioners are actually priests or spiritualists" (p.76).

For some in our study this art of healing is considered a gift bestowed by the Divine. They hold themselves accountable to the responsibility this "gift" places on them.

> *"Role of religion will always be there and it helps in internal check of every person. Fear of Allah Almighty keeps us from doing wrong." (FCGM15)*

The belief in spirituality and the power of spirituality to aid healing through meditation and prayer are deeply embedded in both Eastern and Western religious traditions. O'Laoire (1997), in a US study, found that the amount of time spent in prayers directly correlated with reported significant improvement in self-esteem, anxiety and depression. A very interesting study by Hill et al. (2000) reported greater survival rates at follow-up for more religious individuals while controlling for health-related, psychosocial and demographic variables.

In the current study, patients linked faith-based healing and spirituality to medication and prescription writing:

> *"Doctor should suggest medicine with respect to time of prayer e.g. eat this medicine after performing prayer of Zuhar and Asar, doctor should suggest patient to say prayer. Should motivate by saying, "prayer will result in good health". As doctor is treating patients, patient will definitely follow instruction of doctor and patients will start saying prayer." (PTAM8)*

Bending over to God's will one respondent stated:

> *"Shifa [cure] is in Allah's will, it may be possible that you go to a doctor who is not considered as a good doctor and Allah has kept shifa if we get treatment from that doctor. I would like to share occurrence when Hazrat Mousa (A.S.) was disturbed by the pain in his belly, then he (A.S.) requested Allah Almighty for his treatment and Allah said [to] him to eat one leaf of specific tree and he ate and got rid from pain. After some days, he(A.S.) felt same pain and ate one leaf but could not recover then he ate more one by one, even then he was not recovered and then he requested Allah Almighty, why I am not being recovered by eating the leaves, then Allah said, " recovering from disease is from my order, not in eating leaves; when I said [to] you to eat leaves, you recovered but this time I did not tell you to eat leaves, therefore you could not recover. Recovering from any illness is*

> *from my order and not in eating leaves". Diseases are due to not following Allah's instructions and orders. Patients do same as suggested by doctor, so doctor should advise patients to follow Islamic values; patients will definitely follow." (PTAM10)*

Schoenberger, Matheis, Shiflett & Cotter (2002) found that the majority of professionals included in their US study in the field of professional medicine and rehabilitation endorsed prayer as a legitimate healthcare practice. They found that nurses and occupational therapists were more partial to this practice as compared to physicians and physical therapists. They reported that religious beliefs were firmly intertwined with the practice of patient healthcare management. Their findings are not dissimilar from the findings in my study.

Belief in Divine Retribution:

This component is discussed in terms of the participants' beliefs about mortality and the day of judgement that impacted their views and perceptions related to medical professionalism. Most important perhaps was the stakeholders' identification of the belief in a Day of Judgement as a desirable trait for a professional. Stakeholders identified this belief with keeping true to the moral compass, maintaining the highest professional standards and doing what is best for humanity under all circumstances. One policymaker remarked:

> *"A doctor that fears the day of judgement will never harm his patient intentionally. He will have better attitude." (PMCF1)*

On this Divine accountability one respondent had the following to offer:

> *"Actually education creates awareness about right and wrong; Allah has created and we have the choice to adopt right and wrong, We know if we will do right tasks we will get benefit and if we will do wrong deeds, we will get loss and we have to be accountability for our wrong deeds." (NREF2)*

> *"If there will be accountability of doctors, Allah has introduced the concept of 'Jannah [heaven] & Jahanum [hell]'." (MSJF4)*

This sense of religious accountability is present in all religions and cultures and is not specific to any particular divinity.

The practice of medicine and allied health sciences is thus considered a sacred responsibility which requires the practitioner to answer for his or her actions on the Day of Judgement. A participant from one of the focus group discussions including faculty laments that caregivers do not follow religious instructions in their interactions with patients and interestingly sheds light on the similarity of religious and cultural beliefs:

> *"Monitoring is, there is Jannah and there is Jahanam. Non-Muslims are following instructions of Muslims. We as Muslim just follow few Islamic guidelines and other guidelines we don't follow and neglect. We think that I am good enough to insult you and we do other non-Islamic deeds." (FCIF7)*

The belief in the Day of Judgement was found to be linked with the belief in mortality as is clear from the following quote:

> *"Death is a certainty. We need to be content and continue to serve humanity as our profession demands." (FCLF3)*

In my study, it became clear that a belief in one's own mortality together with a belief in accountability on the Day of Judgement combined with the belief in a Higher Being watching over us was found to be strongly linked with spirituality and a deep-rooted commitment to the service to humanity.

Across all six stakeholder groups, there was considerable consensus in the discussion on the role of religion in health professions. However, there were conflicts and contradictions that were picked up within this theme at the time of analysis. Whereas there was a group that believed in the role of religion and the will of the Divine in all aspects related to disease and recovery from it, there were others who believed that health professionals are increasingly

moving away from religion and its role in their profession as is evidenced from the following quote by a doctor:

> *"I see my fellow professionals observing stringently the timings of five-time communal prayers and portraying themselves to be very religious and at the same time practicing medicine quite unethically." (FCHM1)*

The patients identified a belief in spirituality as something that they look for in a health professional they would consider better than the others. Patients seemed to prefer a doctor that is God-fearing if only because he, in their opinion, holds himself more accountability for his deeds and on account of his religious beliefs will be more likely to act justly, fairly and in the interest of the patients. He will be more responsible. The quote below from a patient in the focus group discussion sums up the expectations of the society in general and the patients specifically:

> *"Yes, a doctor who is a good Muslim will also be a good doctor. He would be afraid of Allah Almighty and [would] believe that he is accountability for his deeds. He will behave equally with the rich and the poor patients and will not have greed for money." (PTAM9)*

The doctors, students and policymakers mirror this belief that the patients express but a number of quotes provided above highlight that the belief is not always matched with action. The belief they profess appears therefore to be superficial and mechanical.

This is particularly important in light of the findings reported in a US study by King & Bushwick (1994), wherein they identified that patients want to have prayer and religious discussion as part of their medical care even though care-givers might consider religious and spiritual matters outside their scope of practice. Olive (1995), in a study based in the US, explored the comfort level of physicians from various religious backgrounds in discussing their beliefs if asked about them by patients. He found that physicians with spiritual beliefs

that are dear to them integrate their beliefs into the various aspects of patient management. In his study he reported that some of the physicians went so far as praying with the patients. Similar findings were reported in a US study by Ellis & Campbell (2005).

Summary of the sub-theme 'Spiritual':

A belief in the divine and its relationship to professionalism as discussed in the proceeding sections seems to be a culturally rooted belief in societies like that in Punjab, Eastern Europe or the United States of America. In these societies, religion is a part of the very fabric of their culture and therefore is reflected in the majority of their activities both personal and professional. This is not true of other cultures, like that in the United Kingdom for example, where religion or personal beliefs related to any form of higher being are clearly demarcated from professional activities. However, the impact that the belief in a higher being has on professionalism cannot be ignored in cultures that have religious foundations in countries like those in the Middle East, the Indian sub-continent and South East Asia, for example.

However, even among our participants, there were individuals who were uncomfortable with linking professionalism with religion. It is very possible for members of a profession to imbibe ideas from outside their own culture, and even to find these in conflict with dominant cultural beliefs.

4.3.2. Subordinate Theme: *MORAL*

The subordinate theme '*MORAL*' is based on the components of: *maintaining a balance between ethics and cultural norms* (including dealing appropriately with cultural taboos); *being non-materialistic, charitable and/or altruistic*; *following one's conscience* and doing the right thing under all circumstances. Also falling within this sub-theme of '*MORAL*'

are discussions concerned with *ethical patient relationships*, like maintaining confidentiality, respecting the autonomy of the patient, taking consent seriously and being trustworthy.

Maintaining a Balance Between Ethics and Cultural Norms:

This section discusses the concepts arising out of the discussions in the focus groups that relate to respecting the right of the community at large, respecting religious beliefs of others and their family values, valuing the effect of role modelling and morality education in developing a righteous moral compass, and balancing patient expectations, cultural and social norms and taboos with ethical practice of medicine. The quote below from a faculty member in the study highlights how she thinks being open-minded and not challenging the belief system of the patient can be of benefit:

> *"You challenge to each person according to his knowledge regarding belief system. You may say to get medical treatment along with spiritual treatment as spiritual treatment will not harm the patient physically." (FCBF9)*

Patel (2018), writing about India, claims that morality education can only be successful if the cultural values and societal norms are morally competent. He suggests,

> "a rational, secular approach that trusts educators to deliver value-based education in India without necessarily strengthening Hindu nationalist tendencies is suggested as a viable way forward" (p.287).

Muslim societies are the products of histories and value systems different from those of the countries but tend to adopt the latter's language and metaphors, such as the 'gift of life' and 'altruism' (Moazam, Jafarey & Shirazi, 2014). Society, its norms and the community shape the development of a behavioural framework to which the majority of professionals adhere:

> *"We cannot say this is professionalism and this is not professionalism because professionalism is an extensive term and it has so many categories, in my opinion important part of professionalism is community which plays a vital role for behaving professionally. We are taught in a well manner by our teachers "how to behave ethically" and our teachers behave so ethically and their moral values are so strong that if we go to our teacher for our treatment of our illness and pay fee*

> *to them they always refuse to receive that fee and get angry and say "Why did you dare to pay fee to me? You are my student and I will not receive treatment fee from you". But now a day[s] even if we know a doctor and send a patient to him, fee is charged without any hesitation. So, medical ethics and professionalism is multifactorial course. There are external and internal factors affecting professionalism." (FCGM15)*

A very interesting quote plucked from the focus group discussions involved physicians identifying the role of social norms in redirecting the moral compass:

> *"This trust will be developed by the society's norms. For example if a person sees that other people are rising and becoming successful by doing wrong things, he will say give up right path and go to the wrong path which is an easy way to success. If a person sees that hardworking people are rising and becoming successful then he will do hard work. Society determines what kind of people would be successful? And when you see the successful person are those who are unprofessional…." (FCBM13)*

However, there can be conflict between the societal norms and the moral compass. This issue was addressed by the policy maker stakeholder groups as follows:

> *"We need to train doctors to respect societal norms but also do the right thing that is professional." (PMCF2)*

Dealing with Cultural Taboos:

In particular, cultural taboos affect our behaviour, social interactions and discharge of professional duties. They pose serious dilemmas in provision of optimal healthcare while upholding sound professional values. One respondent remarked:

> *"In our culture, some people believe in "Jaadu" [witchcraft] and if you say something against "Jaadu", patients will become against you and they will lose their temper. We will not say anything whether believing in Jaadu is right or wrong, if they ask from us." (MSHF3)*

Another participant remarked on how the culture discriminates between working men and women:

> *"In our society it is not acceptable that a female nurse or female doctor attend a male patient. They avoid getting care from them." (NRAF6)*

Under such societal and cultural influences it is perhaps only right that participants of various focus group discussions should refer to challenging norms of society in furthering positive medical professionalism. In various quotes, they have argued that this trait should be an integral component of sound professional behaviours. Regarding the taboo of male nurses in the Pakistani healthcare setup a nurse in the group stated:

> *"There should also be male nurses who are neglected in Pakistan and treating patients without male nursing is very dangerous." (NRBM8)*

Societal norms and taboos have an effect on the behaviour and morality of professionals. Respondents in this study believed that training and teaching in professionalism prepares doctors to effectively reject and repudiate these taboos and do the right thing. This is evidenced from the following quote by a doctor:

> *"I'd like to add something here. When we youngsters enter some field we want to bring change. When we see something bad happening in environment or the thing that we have not been taught throughout life, we try to change that. If you apply such things at the very outset they become applicable but later on, you too go with the wind. I used to shout against my peon's act of sending patients in for just a ten rupee note but now after 12 years that ten rupee note doesn't bother me. Because in the beginning you are not under influence of any factor but later on a cluster of factors influence you like societal pressure." (FCAF14)*

Jha *et al.* (2015) state that culture at the societal level includes mainstream tendencies. It does not, however, involve all behaviours of all individuals in the society. Nevertheless, physicians have to account for societal norms, cultural practices and taboos. Referring to one such cultural expectation, participants of the stakeholder groups recognized refraining from expressing themselves as sexual beings while in their professional capacity of a health professional as an important contributor towards positive professionalism:

> *"A doctor as a professional has no sex. He should be approached as such and he should think of himself as such as well." (PMCF1)*

> *"To a doctor it should not matter whether the patient is male or female. A patient's treatment or management should not be affected by his gender." (MSEF9)*

Shakour, Yamani & Yousefi (2016) explore the factors affecting teaching and learning professionalism among medical teachers. They argue that it is not always easy to do the right thing. The current study also argues that positive medical professionalism requires doing the right thing in all environments and under all belief, rites, rituals and taboos. One respondent remarked:

> *"Some patients have faith & believe on amulet and superstitious things (taweez, baba). They do not have trust in medicines and they come to hospital due to some referral, they rather have faith on these things."(NRAF5)*

It is therefore not surprising that 'power to follow the right path' was identified as an emerging theme from four stakeholder groups, that is, the doctors, the medical students, policy makers and allied health science students.

> *"Most of the students follow what is being practiced. Responsible doctors practice only in a way which is ethical." (MSBF4)*

However, what we practice can be different from what we preach (Griess & Keat, 2014). Goffman (2017) argues that society plays a very important role in shaping role models and their students. On the role of society in influencing the actions of individuals, a medical student had the following to add to the debate:

> *"We follow our society. We cannot change it because we are youngsters. We follow what we, our seniors or elders do. Society does influence our attitude. What we read is not as much effective as what we see and observe. If our seniors are unprofessional we will be like them." (MSDM2)*

Role models play a significant role in influencing our actions and needs, as one medical student observed:

> *"Normally we become doctor by making other doctors as role model but when we become doctor we start seeing these doctors closely and compare our living standard with theirs and then our greed for money increases and we start doing what a doctor should not do and keep on doing wrong until someone prohibits us or we are taught not to do so." (MSEM11)*

Being Non-Materialistic, Charitable and Altruistic:

Another component of the subordinate theme *MORAL* lists certain attributes associated with moral behaviour. *Being non-materialistic* is discussed below within the ambit of the following points extracted out of the discussions: refrains from taking gifts/bribes/benefits from patients, resists exploitation by pharmaceutical companies, is not influenced by appearances and resists economic pressures.

Zavestovskaya (2018) argues that physicians in Russia have adopted materialistic attitudes, putting material gains above the service of humanity. David-Barrett, Yakis-Douglas, Moss-Cowan & Nguyen (2017) noted while reporting behaviours and attitudes of physicians in Soviet Estonia that receiving gifts from patients was considered acceptable by Estonian doctors who were poorly paid.

Health professionals as 'non-materialistic' also came up as a recurrent emerging theme in a number of focus group discussions across the various stakeholder groups:

> *"The fourth and fifth thing is that doctor must come out from materialism, he must behave ethically. Materialism must be eliminated from the medical professionalism." (FCFM8)*

On materialism, one of the policymakers lamented:

> *"It's a rat race for money in this profession. That is what has destroyed it."(PMAM4)*

Not just that, but a good professional is also expected to resist economic pressures and exploitations by pharmaceutical companies. On resisting economic pressures, one of the physicians stated:

> *"If we learn to live within our means and do not run after expensive luxuries, we can be satisfied and concentrate on our jobs and doing the job well rather than running after monetary benefits. But there are doctors who do malpractice only to gain monetary benefits...even write wrong medico-legal reports for money."(NREF4)*

The ability to resist exploitation by pharmaceutical companies was elaborated upon by various participants belonging to the faculty and patient groups only. One physician stated:

> *"If the injection, the company desires me to prescribe to my patients, cost Rs, 1000/- whereas my patients are poor I will not recommend it, I will recommend a cheaper injection of the same quality, even though I will lose the kickback by the company selling the expensive drug."(FCHM1)*

Participants of focus group discussions consistently discouraged keeping appearances above professionalism. A good physician should not be influenced by the apparent wealth or social status of a patient:

> *"Our behaviour change with the getup of a person. If a patient is not well dressed and does not belong to good [social] class, the behaviour will be different from when a well-dressed person will come, the doctor's behaviour will be changed automatically. We are influenced by this patient's appearance. This is not how it should be, moreover we ourselves are quite conceited in our behaviours and actions." (FCFM9)*

Das *et al.* (2018) argued that in some countries with low socioeconomic conditions, corruption was both more likely and more acceptable. Our respondents appear to agree:

> *"It is becoming a norm to accept gifts from patients. This is completely unethical." (PMCF4)*

Speaking out against corruption, one of the nurses in a focus group discussion remarked:

> *"It is against professionalism to get gift from the patient and a nurse loses his self-respect by taking bribery. It is against ethics to handle urgently to the patient who has given you gift and don't handle patient who needs emergency treatment and hasn't given gift." (NREF7)*

Roberson (2016) reported that South African medical students living in an economically challenged environment were willing to sacrifice morality for financial gains if

that is what helped them survive financially. In contrast one of our medical students lamented:

> *"I know some seniors that proudly say that they have not bought any clothing or perfume in decades as they get these as gifts from the patients. This cannot be professional. Right?" (MSEF9)*

Similarly, one of the physicians from the focus group discussions remarked:

> *"They ask their patients, [they] give it [gifts] to them out of love. I do not think it is professionally correct." (FCLF3)*

On *being charitable and /or altruistic*, Wood & Arcus (2011) relate generosity, charity and philanthropy to professionalism. They identify various philanthropic efforts by medics, non-medics and a combination of both towards alleviating human suffering. Amongst the various humanistic attributes identified as emerging out of various stakeholder discussions, being charitable, kind and generous are also important traits. One of the physicians stated:

> *"Charity is not monetary in nature all the time. A good professional can be charitable by giving extra time and working beyond the call of his duty. In my opinion that too is charity."(FCMM4)*

The participants differentiated charity from generosity, perhaps as a function of the Islamic law. Generosity encompassed giving away freely not just money but, more importantly perhaps, time, which was considered more valuable.

> *"I think time is more important than money and to give it freely to your patients is a sign of generosity. I have friends who regularly donate money, time, blood and clothes to patients through societies. This is part of being a doctor." (MSGF10)*

Harris (2018) questions the inclusion of altruism within the set of attributes that constitute medical professionalism. He argues that even though the definition of altruism often remains uncertain for doctors, in various surveys doctors show support for the retention of altruism within medical professionalism. His arguments are consistent with the findings

reported by Hoppe *et al*. (2013) and Chard, Elsharkawy and Newbery (2006). Nevertheless, he finds that arguments against altruism being retained in the definition of medical professionalism appear more compelling. He argues that doctors are an expensive resource and they can no longer be expected to care unselfishly for the patients without regard to their own health and their economic well-being. This, he argues, would put the entire workforce at risk.

Hafferty and Castellani (2009) point to a notion of nostalgic professionalism. They argue that the whole concept of professionalism is seen as out-dated, old fashioned, patronizing and unhealthy by most new graduates. In the current study, the participants idealized notions of altruism and nobleness but their discourse clearly indicated that they realized that altruism was a trait quite rare to identify in the modern times amongst the health professionals. This is reflected in the discussions amongst the focus group participants in this study as well. One of the students in the group commented on how the hunger for money to fuel the demands for leading a better quality of life contradicts with the notions of practice towards altruistic behaviour and sacrifice of self for the good of the patients and the community.

> *"The people here say why should I care for others? People want to earn money and don't work for the betterment of society. People are hungry for money." (MSHF2)*

Another student commented along similar lines.

> *"To serve in a good way for the welfare of people. But it is not practiced everywhere." (MSHF5)*

Personal interests overcome the taught self-sacrificing attitude during studentship and clerkship under the influence of the hidden curriculum. Altruism and self-sacrifice are high ideals that professionals can aspire to, but the realities of the world make it difficult to actually commit to these fully:

> *"This depends upon the mind-set of the doctor who is serving in a village to accept eatables from the patients and making extra income. I would never want to serve in Patoki as that is not Lahore and would practice in Lahore as there are more job opportunities, more pay and less [electricity] load shedding in Lahore. If government pays extra incentives in Patoki then I will serve in Patoki rather than Lahore."(MSEF15)*

Following one's conscience:

Mampane & Huddle (2017) claim that as governments get involved more and more in the provision of healthcare, services that are considered critical to the rights of patients or their welfare will no longer be left at the discretion of health professionals but will rather become increasingly institutionalised. They add that this may bring individuals, groups and the state into direct conflict over issues of conscience. Interestingly, following one's own conscience has been identified by participants in the focus group discussions as an important trait of medical professionalism:

> *"Conscience keeps you awake, if you do wrong, that is the first thing. If you are not aware of your boundaries, if your conscience is there it will keep you away from un-professionalism." (FCEM1)*

A faculty member on following a code of conduct stated:

> *"Society cannot pressurize you as you have your own code of conduct. Societal norms are developed by your behaviour and not that society's belief system should influence your behaviour. As sometimes patient asks to get treatment through injection but we suggest and recommend giving treatment through drip. If society's values and norms influence the doctor's behaviour, then that is unprofessional." (FCBM6)*

Branch *et al.* (2017 p.2320) gathered reflections from eight US medical school graduates on 'their personal motivations and the barriers that impeded their humanistic practice and teaching'. They concluded that

> 'determination to live by one's values, embedded within a strong professional identity, allowed study participants to alleviate, but not resolve, the barriers.

> Collaborative action to address organizational impediments was endorsed but found to be lacking' (p.2320).

However, Shaw, Rees, Andersen, Black & Monrouxe (2018) suggest that, over time, students become emotionally desensitized and passively or actively exhibit negative professionalism traits. In a qualitative study of 808 medical students in the UK and Australia, they highlight:

> 'how students draw on a number of direct and indirect, verbal and bodily, instantaneous and delayed forms of resistance to counter the professionalism lapses of their seniors, which they face in everyday clinical and educational interactions' (op.cit. p.45).

This, they believe, is one of the reasons that students either fail to condemn unprofessional behaviours or are found to be committing them. This inability to follow their conscience, they postulate, is a learned response to the apathy they encounter around them. Friesen & Blease (2018) in their extended essay on the subject agree with the findings of Shaw *et al*. (2018). A study based in the UK by Dennis, Foy, Monrouxe & Rees (2018) claims that these lapses in professionalism by students are not passive. As they committed these lapses, students were found to struggle with internal conflicts which stayed with them over time.

Terhorst, Leach, Bussières, Evans & Schneider (2016) in a study in the North American context, distinguish amongst what is taught, learnt and expressed at the time of examination. They identify the failure of a snapshot examination to capture medical professional values and traits. A faculty member stated,

> *"Students behave in the way they are taught only on the day of examination and will behave in the way in the ward as it is already being practiced in the ward by seniors." (FCCM10)*

This conflict between the teaching and the practice of medicine no doubt erodes the self-respect of the caregivers and impedes their sense of satisfaction in self and the work they do. These two traits, that is, self-respect and a satisfaction in what one does and stand for are also

identified by the participants of the study as something they look for in a professional caregiver. One participant of the focus group discussions involving doctors stated:

> *"I carry my self-respect. I do not want to do anything [professionally] that will put me to shame in front of my patients or colleagues." (FCLF6)*

And another remarked:

> *"Self-satisfaction is when your conscience [is] satisfied." (FCHF3)*

Self-satisfaction was rated very high among the attributes that led to professional discharge of duties especially by medical students. One of them stated:

> *"If you are happy in your profession then you will do it properly and will be in peace."(AHBF5)" (MSHF4)*

As has been noted in some studies above, one of the participants from the medical students' discussion groups commented on the effect of environmental and social pressures that affect professional values:

> "*There should be accountability of students, teachers and doctors. Psychological pressure prevails in the mind of medical students and students are tired of fighting after becoming doctor… A doctor may be victim of any corruption mishap which makes him feeling bad and having negative emotions which will develop [to] prohibit him in performing professionally." (MSIF4)*

The moral belief system is constantly challenged by new evidence, social interaction, socio-economic challenges, shifting cultural and societal norms and changes in regulatory policies and procedures amongst others. One participant remarked:

> *"We are to remain true to our moral compass." (PMCM4)*

Regarding the moral compass an extract from the focus group discussions including patients is presented:

> *"Our moral compass guides us to do the right thing at the right time. We develop this moral compass from our family values, from interacting with other members of the society and through education. We reflect on our actions and on the actions of others and their consequences and then we set our moral compass right." (PMCF2)*

One of the participants in the focus group discussions didn't mince words when he stated:

> *"A doctor is expected to be mentally strong and be able to follow the right path. Belief in himself, in his competence and an inner sense of contentment can help him follow the right path." (PMAM7)*

Physicians might object to referring patients for services they believe to be immoral. The Pakistan Medical & Dental Council Code of Ethics of Practice for medical and dental practitioners emphasizes the right of physicians to refuse treatment to a patient based on his right of conscientious objection. Referral for abortion is one such example. Working against one's own conscience might adversely affect a physician's mental as well as physical health (Camacho, 2016). Reaching out to the conscience of the physicians, one of the participants of the focus group discussions involving patients stated:

> *"Doctors these days do not have a conscience…you know what I mean…they feel that they can do anything, right or wrong and still get away with it…what wrong they do doesn't haunt them like it does other normal people." (PTBF2)*

Herschkopf, Jafari & Puchalski (2017) argue that as health practitioners if someone refuses a particular treatment on moral grounds, they have a duty to inform the patient of their decision and the reasons behind it. Similarly, it is in the interest of doctor-patient relationship that patient should be informed of any medical error (Senders, 2018). This leads us to ethics in the doctor-patient relationship, the final component of the sub theme *MORAL.*

Being ethical in doctor- patient relationships:

Maintaining confidentiality is one of the basic tenets of medical professionalism (Swick, 2000). However it can also be looked at through the cultural and societal norms lens. Feld *et al*. (2015) investigated confidentiality of personal health information in professionalism in a

study in the European context. They identified consistent lapses in confidentiality while sharing identifiable patient information with colleagues using smartphones. Seys *et al*. (2013) reported similar findings of both intended and unintended leakage of confidential information about patients within various communication system frameworks within the healthcare delivery organization.

The participants in this study consistently identified the maintenance of patient confidentiality as an integral component of medical professionalism. One participant remarked:

> *"Yes, in countries like America and Europe doctors are to disclose each and every disease to patients and not to discuss anything to the brother, sister, father, mother or any other relative about the health of patient without the permission of the patient. There are the patients who are the victim of cancer and say don't tell my mother about my disease but doctors disclose confidential information about the patient to his/her relatives and so confidentially cannot be maintained. Professionalism is a wide term and maintaining confidentiality is the part of professionalism. (MSEM4)*

In Pakistan, the practice of taking consent not from the patient but his/her relatives was extensively debated and condemned. This is evident from the following quote:

> *"It is criminal by law as well to take consent from the relatives rather than the patient." (FCCM1)*

On maintaining confidentiality, one medical student said,

> *"We should also not share problems shared by the patient with anyone."(NRBF5)*
> *"Approach toward patients' means behaviour and ethics like patient's autonomy, maintaining patient's confidentiality." (MSEF4)*

These expectations by the society sometimes interfere directly with basic tenets of professionalism. The behaviour of taking proper and complete consent was also identified by the participants of various stakeholder groups as an important contributor to medical professionalism. The following quotes illustrate the point:

> *"There should be informed consent. The patient should know what is going to be done with him." (MSDM4)*

> *"If we have to treat a patient, we will not straightaway start that but we will take his consent first. e.g., if he has some pee problem we will ask him that can we expose him." (NRAF3)*

But here again patient expectations, societal norms and cultural practices come in the way of professionalism:

> *"Most of the time the patient does not sign paper of consent, rather it is signed by some close relative. In case of wives, generally it is signed by husband but it should be signed by the patient." (FCHM1)*

The legal and ethical requirement to maintain confidentiality and obtain valid informed consent to treatment is founded on the philosophical theory of patient autonomy (Delany, 2005). In the modern era the idea of accountability relocates clinical medical autonomy to professional institutions rather than individual doctors. While contrasting modern oaths taken by the physicians at the time of graduation with the original Hippocratic oaths Sullivan (2005) clarifies that the only thing missing in the original is the modern concept of patient autonomy. This concept is guided by the ethical theory and patient autonomy theory amongst others (Robertson, 1996).

Autonomy here can be considered in two ways. One is position autonomy, that is, the doctor's right to offer the best he has to offer under the best conditions that are available. This needs to be contrasted with the Aristotelian explanations of 'virtue ethics' that introduces the modern era concept of conscientious objections of conscience rights: the right of the physician to refuse care on religious/ethical/ moral or cultural belief grounds (Sullivan, 1992).

The second is patient autonomy, whereby once the patient is in receipt of the complete information, it is his choice to accept or discard completely or partially any or all healthcare

(Salloch, 2017). It is the latter that concerns the participants of the study: they expect healthcare providers to uphold the rights of the patients, the foremost of which is his right to choose:

> *"It is doctor's duty to try his level best to convince the patient for treatment but it is patient's right to decide whether he would go for the surgery or not. But a doctor should put all of his arguments in front of his patient." (FCHM1)*

One of the participants in the policymaker group stated:

> *"The patient has the right to decide for himself. Doctors do not have that right. To do so otherwise is unprofessional." (PMAM5)*

On the subject one of the allied health students remarked:

> *"Secondly, you have to follow the ethics if you have a female patient and you are a male doctor and you have started according to your will you have not taken patient's consent whether she wants to apply that on herself or not. They are satisfied or not? Will it have any outcome or not."(AHCF3)*

Similarly, participants of focus group discussions observed that professional healthcare providers avoid frankness with patients:

> *"We are trained from the beginning to maintain professional behaviour and avoid being frank with the patients."(MSDF2)*

Another aspect that emerged out of the focus group discussions is that a medical professional does not develop relationships with patients. Developing physical relations with patients is considered an out-of-bounds activity by the participants of the study:

> *"I mean….like developing relations with the patients is totally unprofessional." (FCLF1)*

> *"There are new cases coming up where doctors develop relations of sexual nature with their patients. Policies exist against such behaviour, but they get away because of their influence. What can we say?" (PMCF3)*

Summary of the subtheme MORAL:

Evidence in the literature suggests that morality could be regarded as forming the bedrock of professionalism. This is validated by the stakeholders in the focus group discussions. They relate the moral compass of the community of practice directly to that of the society at large, its culture, norms and belief systems, but also to the expectations of individual clients. These expectations are again very contextual but mostly driven by a belief system that is very peculiar to the culture: for example, acceptance of the public-private split even with its consequences, acceptance of disparities in wealth and inequalities in relation to gender, a culture of charitable giving, among others.

4.3.3 Subordinate Theme: *HUMANE*

Participants of the focus group discussions repeatedly stressed the importance of having a selfless character, linked with notions like altruism, self-sacrifice, a caring attitude, being noble, humble, respectful and caring. Eidson-Ton et al., (2016) propagated the value of systematically training students and residents for the development of traits that foster professional behaviour including compassion, empathy, kindness, generosity, respect and humility. *Being humane* or humaneness was identified as a trait belonging to a group of components including: showing *empathy, sympathy and kindness*; *showing humility and respect*; and *holding a belief in inclusivity*.

Empathy, sympathy and kindness:

Jha, Bekker, Duffy & Roberts (2007) conducted a qualitative study aiming to describe the views and experiences about medical professionalism that individuals have. Attributes like caring and a self-sacrificing nature were important constructs of a positive professional identity for participants. Our medical students also identified caring attitudes as desirable in a

medical profession and something they felt was appreciated by the others as is evident from the following quote:

"The caring one [physician] will be appreciated." (MSFF10)

On the same subject, one of the participants from the physician group identified affection as something that goes beyond compassion and competence especially in a medical professional who is also a medical teacher.

> *"We're also teachers and we act in medical teaching profession so in our case it is a little different from an ordinary doctor. An ordinary doctor has to be compassionate and competent but a medical teacher then has additional qualities in addition to compassion and competence. Then, he has to be affectionate too because now he is a teacher. An ordinary doctor has to be compassionate but he may not be affectionate but a teacher has to be affectionate….." (FCAM3)*

However, Phillips & Dalgarno (2017) observed that behavioural traits such as compassion, caring, empathy and sympathy were seen as being in contradiction with professionalization. Phillips & Clarke (2012) reported the existence of a very powerful hidden curriculum that competes with the taught curriculum. It is this hidden curriculum that trains students and physicians into the state of emotional desensitization and adjusts them to focus just on the objective task at hand, that is, the task of curing patients. In an another study in the US, Phillips & Dalgarno (2017) reported that the majority of the participants, that is, 21 first year residents, perceived that balancing objective duty and compassionate care was difficult for faculty. This emotional exhaustion, as they put it, was also reported by Azmand, Ebrahimi, Iman & Asemani (2018) in an Iranian study.

Phillips & Dalgarno (2017) believed that as one moves from student to resident to practitioner, health professional trainees experience attributes such as compassion, self-sacrifice, caring and empathy that are such integral components of medical professionalism as being partially or sometimes completely eroded by a professional identity that they

develop as a result of the powerful modelling within the hidden curriculum. Humane traits of professionalism become liabilities that need to be shed in order to be able to function efficiently and without any fear of emotional emersion during the discharge of their duties.

In a very interesting essay Bourgois, Holmes, Sue & Quesada (2017) reported a shift in empathetic attitude as a result of clinical training which resulted in the transformation of a patient from a human individual to an object of work. This mental transformation of doctors, they argue, is important to cope with the psychological load of patient suffering. Thus, physicians routinely distance themselves from the patients and suppress all feelings of empathy and sympathy in an environment that is immersed in misery.

> *"Our sensitivity decreases with the passage of time, when we are in 3rd year we used to weep after seeing worse condition of the patient and in 4th year we used to say, "It doesn't matter" and in final year even patient dies in front of our eyes and we don't bother for it. We should take care of each patient keeping in mind that he may not be so important for us but is important for his family and his family has taken him for treatment by considering the doctor as "saviour". Doctors don't listen to patients and don't allow patients to tell in detail." (MSEF6)*

The physician group recognized the absence of empathy as a substantial loss in medical professionalism:

> *"Not many people, let alone doctors, possess this trait…the trait of showing empathy. It is an absolute necessity in our profession." (FCKM1)*

A comment from one of the patients sums up their plight in the face of lack of empathy exhibited by healthcare providers:

> *"I have come from Jhang (a distant-city) and I am employee in an institution and if I have to wait for doctor for whole day due to lack of reference and doctor tells me to come after twenty days, my institution will not allow me to be on leave for twenty days per month." (PTAM6)*

Like empathy, sympathy too, it seems, is eroded over time through this desensitization process (Holmes, Harris, Schwartz & Regehr, 2015; Monrouxe, Rees, Dennis & Wells, 2015; Lynch, Surdyk & Eiser, 2004):

> *"Usually desensitization comes with the passage of time. When we see other doctors doing wrong first time, we will not consider him wrong person and with the passage of time we don't consider his action as bad act and we can't be role model for our seniors as we still have not reached to their level. " (MSEF12)*

Participants in the policymaker stakeholder group were clear that sympathy towards patient suffering has no place in the healthcare delivery system. One of the participants retorted:

> *"There is no room for sympathy in this profession." (PMAM7)*

This perhaps is in keeping with the teachings of Veloski & Hojat (2006) that discriminates and distinguishes between the concepts of empathy and sympathy. They argue that sympathy is an affective attribute, while empathy a cognitive. Empathy requires understanding patients' perspectives and the ability to communicate this understanding. It is, therefore, not surprising that the policymaker group highlighted sympathy as illustrated in the quote mentioned above. Whereas for empathy, they clearly attributed it to a cognitive response to a patient's suffering as is evidenced from the following quote:

> *"He should place himself in their shoes and wonder if he is doing the right thing." (PMCF1)*

Participants observed that like other humane values, health professionals tend to suppress kindness in their professional interactions in order to 'bracket off' their emotions while at work.

> *"Kindness is a virtue few doctors possess these days. This is not what it used to be 20-30 years ago. Too much has changed in the profession for the worse." (PMBF4)*

Salloch (2017) concludes that a distinction exists between ethics in medicine and professionalism. She believes that medical professionalism has borrowed heavily from the

domain of ethics. She argues that giving in to the idea of professionalism may lead to elitism and exclusively monopolizing topics which perhaps fall within the domain of medical ethics and outside professionalism. On the other hand in this study being open-minded, comforting and reassuring, three traits identified as humane values, were perceived by the participants to be within the domain of medical professionalism rather than medical ethics. One of the medical students in the quote below clearly links comforting with professionalism.

> *"If a doctor talks patiently with patient and makes him understand, the patient will feel better. Professionalism is not only the external factor but internal factor which patient feels." (MSGF10)*

Reassurance alone, one of the patients remarked, can make a whole lot of difference.

> *"Half of the patients became good by the attitude of the doctor. If doctor gives courage to patient; feels himself fine." (PTBM1)*

From the focus group discussions involving patients, it turned out that patients are particularly affected at the emotional level by the uncaring attitude of the doctors. One of the participants lamented:

> *"I am from Mian Chanu. [a distant peripheral town in Punjab] I went to a hospital, but the attitude of the doctor was not good there. He had an uncaring attitude." (PTBM1)*

Showing Humility and Respect:

Together with a caring and considerate attitude, humility, respect for the patient and self-sacrifice are the traits that emerged as expected constructs of a sound positive professional identity. One faculty member in the group remarked:

> *"Doctor has to show humility. He is in service of humanity and should behave humbly."(FCLF6)*

On the subject, one patient had the following to offer:

> *"A doctor will be called good doctor if he behaves humbly, politely and respectfully." (PTAM1)*

And from another participant:

> *"Doctors do have pride complex, this pride don't allow doctors to talk with patients properly. Society needs people of all professions and doctors should consider themselves as normal man for working professionally." (MSIF4)*

However, the following quote from one of the patients sums up their perception regarding the humane values of professionalism in relation to their own priorities:

> *"Behaving humbly and patiently is the moral duty of doctor but treatment is more important than merely behaving well while lacking skills for treatment." (PTAM2)*

While identifying and valuing respectful behaviour as an important attribute the participants recognized its erosion over time amongst physicians:

> *"We don't give respect to patient and we don't listen all information from patients. All patients should be given information at the patient level. "Rights of the people" is more important than "Rights of God". If a doctor comes late even at 12:00 a.m. and go to home at 4:00 p.m. he knows that he is not earning Hilal (earnest) Livelihood. We should think about it to behave professionally. We should take care of ethical, moral and religious issues." (MSGM3)*

A Belief in Inclusivity:

Jalil, Zakar, Zakar & Fischer (2017 p.12) in their Pakistani study specifically recommend that

> '..,in order to bring [health] services into line with the expectations of patients, the tolerance level of physicians for dealing with illiterate and poor patients should be improved, through learning expression management skills. Additionally, advanced training sequences should be organised to train doctors to deal with patients coming from the lowest strata of society'.

Jha *et al*. (2007) in their qualitative study on exploring the perceptions of professionalism in medicine derived from medical educators, medical students, medical doctors, allied health professionals and lay professionals reported 'treating patients equally' as an important behavioural trait embedded within medical professionalism. Our participants agreed:

> *"We see lots of patients, lots of deficiencies amongst them. They belong to different religions, different races, different socio-economic backgrounds. Professionalism enables practitioner to treat everyone regardless of their area of living, life standard or their religion." (AHEM1)*

This links inclusivity to tolerance. The theme of 'tolerance' transcends contextual, situational and cultural intelligence and extends beyond into sexual, religious, economic and literacy tolerance. From out of the analysis of the focus group discussions in the current study, this theme emerges with its own place in the framework of medical professionalism:

> *"I know a doctor who is a good orthopaedic surgeon but he prefers the people of his sect and in this way professionalism is compromised. Doctors wants to treat the people of their religion and patients also get treatment from doctors of their religion." (MSGM7)*

Dugdale, Siegler & Rubin (2008), reporting five significant challenges to the delivery of the medical care in the current century that need to be understood in order to provide appropriate care to our patients, identified just and fair distribution of resources as one of these challenges. In this current study, the participants required medical professionals to behave with impartiality and be just and fair in the discharge of their duties as is evident from the following quotes:

> *"You will try your best to behave with all equally. Like don't treat those people who are uneducated because they don't know nothing and it doesn't matter that I explain the things to them or not." (AHEM1)*

> *"A doctor should perform without considering socio-economic factors as a doctor should not suggest costly lab-tests to the rich patients and should suggest lab-tests from the labs where good quality of lab-tests is being provided. If we should also not consider the factors like culture and religion as a doctor should treat in the same way to the patients of all religions." (MSIF6)*

However, as well as being just, the allied health sciences students as well as medical students identified that a sound professional should also be considerate.

> *"We can charge the patient according to his economic status." (AHAF3)*

One of the medical students remarked:

> *"It is not humanism that a patient is in critical situation and you are saying [to] him to submit fee first [and] then I will treat you. You should also see the patient's condition along with your fee and should also consider the early treatment of the patient." (MSBF8)*

Summary of subtheme HUMANENESS:

Humility, inclusivity, empathy, respect for others and their belief systems, kindness and a caring attitude towards others in general are some of the basic attributes that the literature evidence from the rest of the world identifies as the foundation of professionalism. The same traits have been identified by the participants of this study in their sense-making of professionalism. These traits may however vary from culture to culture and from one society to another based on existing belief systems, moral structures and socio-economic and class systems. Hence the meaning of these attributes needs to be interpreted contextually.

4.3.4. Summary of VALUES-DRIVEN

> *"For a doctor, professionalism, it is not enough to have desired experience but ethics does matter a lot. Like how to speak and how to behave. If I go to a mechanic I do not care for his personal character but if I go to doctor I notice the personal character of the doctor." (FCDF2)*

The superordinate theme 'Values-Driven' incorporates the values, beliefs and moral system of the professional in particular and the community of practice in general. In the preceding sections it has been argued that strong personal values, excellent behaviour and sound morality are hallmarks of medical professionalism. The findings of this study are tin consensus with literature evidence from the rest of the world that argues that medical professionalism aspires to the highest humanistic values, beliefs and moral systems. However this comes with the caveat that the understanding of what is considered best or optimum behaviour is largely dependent on the culture of a society and the context in which that

behaviour is being evaluated. As Blinman (2017) argues, professional practice comes close to being whatever some individual or group deems it to be. He argues that individuals within the group or a group as a whole may refer to their own pre-existing moral commitments or the profession and society may chart out together a moral code for the profession. This code may then be strictly adhered to and enforced in all cases (Blinman, 2017).

Values are no doubt an integral component of medical professionalism but it is the society and belief systems that define which behaviours are acceptable and which are not. As Branch *et al*. (2017) found when they gathered reflections from eight US medical school graduates on 'their personal motivations and the barriers that impeded their humanistic practice',

> 'determination to live by one's values, embedded within a strong professional identity, allowed study participants to alleviate, but not resolve, the barriers. Collaborative action to address organizational impediments was endorsed but found to be lacking' (p.2320).

4.4. THEME 2: ADEPT

> *"For a doctor behaving professionally, he should have perfect knowledge which is understandable and should have required skills, should work for giving advantage and benefit to the patients." (MSEF3)*

> *"I think a lot of discussion has been made; whatever a profession a person adopts whether plumber, engineer [he] should have his training of profession. Personality factor whether he is fit for this profession. Qualification, proficiency and safety are main factors that have the impact on professionalism; he should be competent and with monitoring authority, better output can be achieved. Even Allah has introduced monitoring system by Reward and Punishment structure. If you have a monitoring system and regulatory authority, better results can be achieved." (FCDM6)*

The second theme, ADEPT, develops out of a combination of sub-themes and components referring to different aspects of skills and their application. Schmeiser (2006) proclaims that one of the fundamental aspects that defines professionalism is the possession

of a specialized and up-to-date knowledge related to that profession. This is the pre-condition for fulfilling the high expectations a society has of professionals. Being up-to-date and having at least the required minimum professional knowledge and skills enable medical professionals to manage patients and interact with peers in society. We found at least some consensus in the literature on the requirement to possess whatever qualification is regarded as the bare minimum for registration to practice; and that the qualification should confirm possession of the education, skills and certain core behaviours that can solely be attributed to that profession and not to any other profession (Schmeiser, 2006). Keeping abreast with emerging knowledge and skills and even behaviours associated with them is also a requirement for staying within the Community of Practice (CoP):

> *"You must know your work and its standards, if there is any lack in knowledge, how you will do your duty?" (NRCF1)*

Thus the first sub-theme is labelled COMPETENT. There is however also an attitudinal aspect falling within this theme related to taking responsibility. RESPONSIBLE emerged as a multidimensional construct built on responsibility for self, towards peers, patients, the public, the profession, the government, one's inner conscience, the regulatory body, society, culture, religion, family and friends:

> *"I think professionalism can be attained when you are working with knowledge, skill, honesty and confidence. Then we can develop professionalism. Sense and responsibility are important, just bookish knowledge is not enough. Our positive attitude, it must be there. I should know, at this time, this patient requires the counselling, if he/she does not understand our advice so we can use alternate methods to counsel him/her that is good or it is bad for your health. If your colleague or some other nurse come[s] to tell you about your patient's needs or the patient is not neat, he/she needs medication, physiotherapy or anything other, it shows professional attitude; if she is not providing these things she is unprofessional." (NRAF3)*

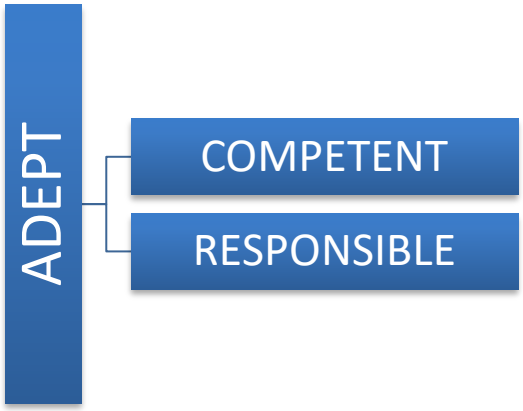


Figure 4.4: Superordinate Theme: ADEPT

4.4.1. Subordinate Theme: *COMPETENT*

Within the sub-theme COMPETENT are important constructs that relate to *learning knowledge and skills*. Patient safety and evidence-based practice. In relation to learning knowledge and skills, participants of the focus group discussions consistently referred to *qualifications and education*; *a commitment to lifelong learning*; *being a reflective practitioner*; and *learning from experience* as important elements that they thought should be fundamental components of medical professionalism:

> *"Professionalism is a wide term, let us start with the example of doctor, he should be competent in his field and how he applies ethical values in his Practice. The basic thing which we consider is his education……..his ability to seek out new knowledge and skills to stay abreast with emerging trends and the fact that he is competent in every aspect of his profession…." (FCDF1)*

Qualifications and education:

Freidson (1999) stated the opinion that health professionals hold qualifications that give them exclusive rights to their profession as these qualifications are too advanced to be shared by a non-member of the profession. Not surprisingly, patients too identified qualifications, education and skill as important constructs of medical professionalism. Speaking on the subject of qualification, one of the patients remarked:

> *"…. we can consider the qualification of the doctor before getting treatment from him as qualification is tool for assessing a doctor's professionalism." (PTAM11)*

On the subject of skills, another participant from the focus group discussions involving patients stated:

> *"Doctor's personal skill for treating the patients will make him good doctor. Good doctor should have skills for the treatment of patients……" (PTAM2)*

Education was not regarded myopically as education in medicine alone. The emerging theme from focus group discussions on education recognized it as a multi-dimensional construct including education about values, social norms, the humanities, science and technologies, amongst other aspects, from cradle to death. One of the faculty members remarked:

> *"Yes, society and education do affect professionalism. Alexander said, give me good mothers, I will give you good nation. Education starts from home and what we do is sometimes intentional and sometimes unintentional….we do what we see." (FCJM1)*

However, knowledge was specifically identified as related to a doctor's professionalism as is evident from the following comment:

> *"Because even if they [other professionals] do not have proper background knowledge about their field, they can work on it but if a doctor does not have knowledge about a specific disease, about causes and symptoms how can he treat a patient? So, there is difference between profession and occupation." (AHAF2)*

Linked with the constructs of qualified, educated, skilled and knowledgeable is another to do with being a good diagnostician, as evidenced from the following quote:

> *"The professionalism of doctor includes serving the patient, good management, good diagnosis and good patient handling." (FCGM1)*

It is expected of a health professional to arrive at the diagnosis using as few resources as safely possible. This economy of diagnosis is valued by the majority of stakeholder groups, though interestingly not by patients and nurses. However, one of the students in the focus group discussions stated:

> *"A good doctor should be able to arrive at the diagnosis from listening carefully to the patient and through examination…but now, everyone wants to get the laboratory or radiology tests done and then diagnose…they do not bother to diagnose using their diagnostic skills learned in their education and training." (MSBF3)*

Commitment to Lifelong Learning:

Wald, McFarland & Markovina (2018) remarked that older practitioners criticized how little about the practice of medicine young graduates know while being taught a great deal about the mechanism of disease. The study by Jahan, Siddiqui, Al Zadjali & Qasim (2016) in Oman reported quantitatively that more students than faculty members in their sample valued maintaining up-to-date knowledge and skills. In the current qualitative study, all stakeholder groups frequently emphasized these attributes presented by Jahan *et al*., assigning value to continuing professional/personal development. Knowledge, participants believed, needs to be updated in order to continue to behave professionally:

> *"He has to keep abreast with new changes in his profession. Like, I mean, update his knowledge, his skills. We have doctors whose knowledge is 40 years old, as old as the day they graduated from medical college. Would you call them professionals?" (PMBF5)*

> *"We should continually strive to upgrade our knowledge and skills. There is so much evidence available on new knowledge and skills on the internet. We must use that to help our patients." (MSCF1)*

Shakour *et al*. (2016) in their study in Iran explored the impact of teacher training programmes on teachers, students, educational institutions and society. They concluded that 'improving professional behaviour in university faculty members can have direct and indirect effects on improving the society due to their crucial role' (Shakour *et al*., 2016 p.1). Participants of focus group discussions from amongst the various stakeholder groups also identified that a sound professional should be a good teacher and a good trainer:

"A good doctor trains his juniors under him to be better than him in every aspect." (PMCF4).

Clyde, Rodríguez & Geiser (2014) in their study in the US suggest that professionalism and professional behaviour should be developed, beyond just teaching topics of professionalism. On the other hand, Rehman *et al.* (2013) identified an absence of faculty development programmes in institutions in Pakistan. They argued that if these were present it could help improve professionalism. Professionalism, they claimed, is something that students and health professional interns learn not as part of the taught curriculum but as something extra, as part of the hidden curriculum. They suggested that this was not enough and would likely lead to mal-professionalism. They recommended that professionalism should be made a part of the studies so that professionalism is learnt explicitly rather than implicitly.

Unfortunately, in the majority of the settings worldwide, these faculty development programmes are not based on an assessment of faculty needs. In fact, there are programmes that fail to identify professionalism as a topic for faculty development (Marmor & Sullivan, 2015). Cruess & Cruess (2008) on the definition of professionalism recognize it as based in a socialization process during which people gain the necessary values, interests, knowledge of their profession, skills and attitudes. They argue that professionalism learning and teaching is complicated as it is both situational and contextual. Thus for them, the objective of a successful faculty development programme that teaches and trains situationally and contextually relevant professionalism should be to produce appropriate role models. This would require developing a flexible programme that teaches and trains in professionalism, a programme that is both responsive to the needs of the faculty and is informed by situation and context.

Our participants agreed:

> *"Refresher courses should be attended by doctors so that we can update our knowledge and can behave more professionally. We are working at specific place and don't know what is going around us. We think we have enough knowledge and skills. The basic purpose of research is to indulge in what is going on around us. I think, refresher courses and small projects should be introduced for the doctors in each institution and there should be specific period in which the project should be completed. Then you may engage your students, then you can also engage your faculty. In this way, your faculty will properly reply to the questions what the students wants to ask, otherwise faculty will pretend that they know everything and will not admit what is not known to them." (FCIF5)*

Being a 'reflective practitioner'/ Learning from experience:

Striving for excellence in one's profession is a concept that extends beyond competency. It extends beyond acquiring the minimum knowledge, skills and attitudes required to practise the craft safely. It is the state of being that requires critical practice, reflective thinking and transforming thought into will and will into practice.

Beyond formal programmes for updating knowledge, skills and attitudes, a commitment to lifelong learning involves reflecting on one's own experience. Branch (2015), in a study of faculty development programmes around the world for professionalism with a practical and theoretical underpinning for teaching professional and humanistic values, came to the conclusion that experiential and reflective learning positively impacts participants. Chretien & Tuck (2015) on the topic of reflection and reflective writing stated that the two are deliberate processes to develop understanding and future actions. Al-Rumayyan *et al*. (2017) endorsed the value of reflection but also cautioned that the term is used indiscriminately and without proper understanding. If the reflective practitioner is valued as a model practitioner, then reflection and reflective writing needs to be taught, learnt, practised and supervised.

Reflective practice leads to self-awareness, awareness of one's strengths and weaknesses. A reflective practitioner is a safe practitioner, a practitioner that has the ability to identify his limitations in real time, which could lead to early referral and safe patient handling. One of the participants of the policymaker stakeholder groups stated:

> *"A professional doctor is expected to review and critically reflect his practice and improve on it." (PMBF1)*

'Values experiential learning' and 'learns from experience' emerged as two separate ideas out of the focus group discussions. 'Learning from experience' related to the motivation to change behaviour and action or to improve skills and knowledge following a threshold event, as, for example, is evident from the following quote:

> *"It depends upon the personality of an individual, some people improve themselves after punishment but some people repeat the same action even after getting punishment. Training also does matter." (FCDF2)*

A similar comment identifies 'learning from experience' as a separate emerging theme related to competency:

> *"Every experience in the workplace or learning and training environment provides opportunity to learn. One needs to ponder over what went right and what was not so good in that experience and adjust accordingly in the subsequent experience. One experience informs another sometimes unrelated experience." (MSGF10)*

In comparison, a practitioner that values experiential learning literally values learning practically in order to attain the minimum standards of practice that would qualify him to be admitted to the community of practice:

> *"In our country, there are two areas. One is to pass the examination and the other is to practice. These are entirely different from each other. In our examination system, these two things are not linked. Academically, when we have to pass the examination we only cram and have no meaningful practical evaluation. We perform practically only after passing the exam. And in my opinion we learn more after we have passed the examination. If we link these*

two things while teaching, it will be very productive and influential." (FCHM1)

A health practitioner who values experiential learning and who learns from experience should be thought of as a professionally experienced practitioner. One might expect that such professionally experienced doctors will demonstrate the best professional traits such as up-to-date knowledge, teamwork and good communication skills. This, however, might not always be the case. Our findings are consistent with the findings of Joynt, Wong, Ling & Lee (2018) who identified that students in medical schools in Hong Kong regularly complained about how their early ideals did not meet the reality of work place exposure especially with senior clinicians.

"It is seen that somehow the more experienced doctors, the ones with the most experience in professional life are the most uncaring, rude and authoritative people." (FCEM1)

Joynt *et al.* (2018) reported significant negative effects on the psyche of students while Bowen (2018) reflects that when role models, especially the more experienced ones, are not what students thought they should be, this affects learners considerably adversely.

An important mechanism to support reflective practice is the ability and willingness to learn from feedback. Butani, Bogetz & Plant (2018) in a qualitative analysis of paediatric residents' perspectives on educational values of patient feedback commented that residents valued feedback especially if it was aligned with their self-perceptions. They responded to feedback in three ways: by feeling like a bad doctor or by ignoring the feedback or by reflecting on the feedback to improve. Many doubted the accuracy of feedback. Other studies have reported similar findings (Shrivasta, Shrivasta, & Ramasamy, 2014).

In the USA Grus *et al*. (2018 p.451) believe that valuing feedback requires another set of attributes that include critical thinking and reflection. This allows for individuals to look at themselves with fresh perspectives and this in turn promotes change. A thoughtful

professional is one who is capable of gathering information from a variety of sources. Like someone doing a 360 degree evaluation (Stark, Korenstein & Karani, 2008) the thoughtful practitioner keeps himself informed of the result of his behaviour towards his peers and patients.

> *"One needs to be thoughtful to be a good doctor. Not work like a robot but think and then act." (FCIM1)*

A female medical student in the current study commented on the topic as follows:

> *"We can get feedback of the patients and comments of the other senior doctors who are working in our surroundings are also mode of measurement of a doctor's professionalism. By this way a doctor will have knowledge and practical implementation of latest techniques." (MSBF9)*

One of the participants from the focus group discussions involving doctors remarked:

> *"The ultimate stakeholders like consumer are very important. If I am providing services and anybody who asks me: are you dealing professionally? I would reply that I am behaving professionally but to whom I am serving will tell accurately how I should behave and what should be rules which I am needed to follow." (FCBF5)*

This in turn drives self-improvement and health practitioners as health professionals learn from experience. Tennhoff, Nentwich & Vogt (2015) in a Swiss study point out that general learning from experience can only take place provided serious value and consideration is given to feedback through reflection and critical thinking.

Summary of 'learning knowledge and skills':

Jha *et al*. (2006) in a qualitative study in the United Kingdom highlighted seven themes that emerged from their study: compliance to values, patient access, doctor-patient relationship, demeanour, professional management, professional awareness and motivation. None of these themes related to acquiring the core knowledge and skills needed for qualification - elements identified in the current study, namely, holding initial qualification/being well-educated, committed to lifelong learning and reflective practitioner/learning from experience. It seems

as though the participants of their study had assumed that the medical professionalism they were talking about related to individuals who were fully qualified, skilled and up-to-date by virtue of being part of the community of practice of health professionals.

In contrast, this current study, which cuts across all segments of society in Pakistan that have a stake in healthcare education and delivery, demonstrates that stakeholders require a professional to be first qualified having the requisite education, having learnt the essential skills and behaviour to practise his or her craft. Only then do these respondents build upon the foundation stone of a professional by adding other values they associate with medical professionalism.

Commitment to Patient Safety:

Attributes that identified the health professional as 'safe', 'fit' and 'best care-giver' were also identified as fundamental to professionalism by the participants of the focus group discussions:

> *"A health professional is one that is able to practice safely, I mean, his intervention leads to good not harm….there are so many quacks out there that are prescribing wrong medicines and doing wrong procedures…a true health professional provides health at the time of illness and not vice versa." (FCHM3)*

In their study in the United Kingdom, Monrouxe & Rees (2012) collected narratives in which participants reported extreme cases where patient safety and dignity were compromised largely due to not maintaining minimum standards of practice and/or not following standard operating procedures (SOPs). In our study, the attributes, 'best care giver', 'maintains minimum standards of practice', 'follows SOPs procedures and protocols' were unanimously gathered except, interestingly, from the patient group. One of the doctors gave the following statement that related to following SOPs, procedures and protocols:

> *"If you are working in an institute, you must abide the rules set by the institute, i.e. coming or going at the right time." (FCFM3)*

In order to abide by these rules, one needs to be well versed with the policies, procedures and regulations of that institution, generally of the profession and certainly of the regulatory body. Lack of awareness of the same can lead to lapses in professionalism and negligent care, as one of the medical students remarked:

> *"How many doctors are aware of the policies and procedures of the institution they work in or of PMDC or the government? How will they behave professionally if they are ignorant of these?" (MSIF3)*

From the nurse stakeholder group, one of the participants commented:

> *"It is not good that some people are doing it one way and other people are doing it in a different way as your priority is your patient and they should be treated in one way. Patient needs the confidence then you can adapt yourself according to patient." (MSHF15)*

The participants however argued that in the current healthcare system, health practitioners were frequently deviating from procedures and protocols and were not maintaining minimum standards of practice. This, in turn, was leading to a wide range of errors and failures in patient care (Cruess & Cruess, 2008). A comment from a nurse sums up their feeling:

> *"Yes, next time we will also do the same if no one following [SOPs] why should we." (NRCF7)*

This comment highlights how in the absence of a system of monitoring and accountability a culture of negligence and neglect can so easily creep in.

Being able to recognise one's own limitations is a key aspect of commitment to patient safety in both initial and continuing medical education. This is explicitly stated in the UK's *Tomorrow's doctors: outcomes and standards for undergraduate medical education* (General Medical Council, 2009) which states that 'the graduate should be able to recognize

personal and professional limits and be willing to ask for help when necessary'. Medical errors are being reported nowadays more frequently than ever before. This is perhaps not because there is a rising incidence of medical errors but more likely it is due to the rising awareness of the public especially the patients regarding their rights, common diseases and the hospital system. Easier access to any and all information on websites and similarly an easier access to litigation services may be contributing factors. McCammon & Brody (2012) argue that reforms in healthcare services that are both patient-centred and physician-centred are required, amongst other things, to reduce the number of incidences of patient harm and thereby reduce the number of litigations against physicians.

Medical negligence and medical errors are related terms but differ conceptually and characteristically. Medical errors can arise in the absence of medical negligence. Medical errors are adverse consequences that occur during the course of medical treatment but are not the result of negligence on the part of the healthcare provider, whereas negligence occurs when a healthcare provider fails to provide an acceptable standard of care to the patient (Dovey *et al*., 2002). However, medical negligence does not find any room in the practice of the professional as is evident from the analysis of the focus group discussions in the current study. One of the patients remarked with tears in his eyes:

> *"Sir I went to Nishtar and remained there for 15 days. My son was treated there and then they said he is fine you may go now. But his headache was there. Someone told me of this hospital. I came there and doctor checked my child and said he is ok but I said please prescribe some test for my satisfaction and when the report of MRI came they said he will be operated…if they had checked him properly first then there was no need of it. One surgery was done but he was not ok now they have done another surgery. I am a poor man I can't afford but due to doctor's negligence I am bearing all of it." (PMBM5)*

According to Tsen, Shapiro & Ashley (2017), the majority of cases of medical negligence arise as a consequence of physicians doubting their own clinical judgements even

in straightforward cases. This leads to patient harm which is not deliberate. Clinical practitioners, they argue, need to be trained better in believing in their clinical acumen and in consulting peers and seniors when in doubt. They should be aware of their limitations and their competence level in order to seek out help from other professionals when and where the situation demands. Participants in the various stakeholder groups identified that good practitioners are those that know and understand their self-limitations:

> *"There is difference between what we know and what are we pretending that we know. We don't accept what is not known to us. We don't polish our teachers and our student also suffers. We don't say this is not known to me and let's see it." (FCIF4)*

Commitment to Evidence-based Practice:

Holm & Williams-Jones (2006) state that it is the moral obligation of every physician to acquire current knowledge and skills and to use the best available empirical evidence to make clinical judgements. Karimian, Kojuri, Sagheb, Mahboudi, Saber, Amini & Dehghani (2014 p.170) argue that,

> 'the decision-making process in medicine is affected, to a large extent, by one's experience, individual mentality, previous models, and common habitual approaches, in addition to scientific principles. Evidence-based medicine is an approach attempting to reinforce scientific, systematic and critical thinking in physicians and provide the ground for optimal decision making'.

Salloch (2017), a German scholar, argues that the practice of evidence-based medicine is almost synonymous with professionalism. She however cautions that these two concepts are over-idealistic. She links evidence-based medicine with altruism, an attribute which is similarly criticized as over-idealistic in literature (Svensson, 2006). Salloch (2017) believes that evidence-based medicine may not fully account for the interests and needs of the patients. She focuses on,

> 'three key aspects of medical professionalism which may come into conflict with the basic tenets of EBM. The potential tensions between (a) professional

> autonomy and clinical practice guidelines, (b) individualised care and standardisation, and (c) esoteric authority and public accountability' (2017 p.61.)

She concludes that these challenges inherent between evidence-based medicine and professionalism are only superficial in nature. She suggests that the shared aims outweigh the tensions between the two.

In the current study, searching for and using evidence to inform practice emerged as one of the major facets of professionalism. One of the most interesting quotes regarding the value of research in shaping medical professionalism comes from a medical student:

> *"A professional should focus on research to further the knowledge and practice of his Community of Practice." (PMCM2)*

Karimian *et al*. (2014 p.170) in their study from Iran conclude that 'to develop the evidence-based approach, it is necessary for educational programs to continue steadily and goal-orientedly'.

In order to make evidence-based decisions in the clinical settings and to make grounded diagnosis, doctors should be able to critically appraise and use research (Marton, McCullough & Ramnanan, 2015). Research also allows students and practising health professionals to stay abreast of recent advances in theory and practice (Chakravarthy *et al.,* 2011).

Summary of subordinate theme 'Competent'

To possess the minimum standards in skills and knowledge as defined by the community of practice is an important component of professionalism. These standards are to be maintained by the regulatory bodies through a process of regulation and accountability. The world literature on the topic and the participants of the research study were in consensus on this aspect of professionalism. However, there still existed differences which can only be

described as cultural in nature. As for example, research and innovation that in the world literature was considered an important component of professionalism was not considered the same by the majority of the participants. Research and innovation is not commonly undertaken in the Pakistani academic culture and where it exists it is superfluous and inconsequential. Hence the participants of the study did not recognize the same as a major contribution to professionalism. Another cultural difference existed in how patient safety was viewed by the participants. The participants related patient safety to workload and Act of God rather than a responsibility of the physician. Lifelong learning and keeping up to date were very infrequently brought up again on account of the culture in Pakistan that does not support a requirement for continuing professional development and consultants by virtue of their seniority continue to practise age-old traditions and skills without change, in sharp contrast to the West.

4.4.2. Subordinate Theme: *RESPONSIBLE*

Our data revealed 'RESPONSIBLE' as a subordinate theme emerging out of a family of many related attributes. *External accountability*, *self-accountability* and *recognizing responsibility to profession/ community of practice* are three constructs that have been related to responsibility. Ellis & Campbell (2005) and Camacho (2016) proclaimed that, generally speaking, physicians hold themselves socially and professionally responsible to the patients. As part of this professional responsibility, healthcare providers are required to approach their patients holistically. Approaching patients holistically requires the healthcare provider to look at the patient as a whole and to treat the patient, not just the disease:

> *"A patient comes up to a doctor with an illness. The doctor should not just focus on the pathophysiology of that illness but try to capture the whole picture by taking family history, past history, social, psychological and occupational history." (PMCM5)*

External Accountability:

Tilburt *et al*. (2013) in a cross-sectional survey including 3897 randomly selected US physicians go on in their study to redefine medical professionalism as a '…belief system about how best to organize and deliver healthcare… [and to] declare what …patients can expect regarding competency standards'. Preston, Larkins, Taylor & Judd (2016) in a study questioning 'how social accountability is conceptualised by staff, students and community members associated with four medical schools [two in Australia and two in the Phillpines] aspiring to be socially accountability ' (p.987), support the notion of an institutional culture within which both faculty and students are held accountable for their professional behaviour.

In the UK, much emphasis has been placed on accountability. The importance of accountability by peers, seniors and institutional management is evident from the role played by a series of medical scandals in the UK, in the mid 1990's onwards. Dixon-Woods, Yeung & Bosk (2011) argue that these resulted in the end of the collegial model of self-regulation, which had lasted for 150 years in that country. They argue that this collegial model of self-regulation left the profession under threat from the 'bad apples' within it. In the absence of a monitoring and supervisory system, it is quite easy for practice to deteriorate over time especially under the influence of the prevailing environmental factors, as one of our participants noted:

> *"Basically, it's two-way traffic; like when I started teaching, I used to do a lot of preparation for teaching and was expecting a number of questions from students but with the passage of time, I knew that students are not taking interest in their studies and not asking questions and then my preparation level came down."(FCIF11)*

McGurgan, Olson-White, Holgate & Carmody (2010) noted that until quite recently the United Kingdom was the only country in the world that provided national guidelines on the

professional conduct of medical students. In other countries, individual medical colleges were found to have institutional guidelines.

The regulatory effects of a medical council and of a college were highlighted by participants in the focus group discussions:

> *"Pakistan Medical and Dental Council was established primarily…I think...to safeguard the interests of the public. They cancel the license of the doctors who are found to be unprofessional." (PMAM5)*

> *"Few years back our institutions provided "education and training" but now our institution only provide education and element of training is missing. Now our institutions have become business centres and teachers are also business-minded and students don't consider teacher as their parents and think that "I am paying money to the teacher". One of my colleagues who is teaching in a military college told me that I tried to regulate the timing of my students but parents of these students visited principal's office against me and said their children are right so I should not observe their timing and parents also said that teacher's task is to provide knowledge and skills, not regulate timings and punctuality."(FCBM11)*

> *"Authorities are there, check and balance and reward and punishment are also there. Without it you can't do well." (AHDM4)*

Shukr (2014) also identifies another function of the regulatory bodies in medical colleges, that of developing and providing medical policy based on which disciplinary action against doctors and students could be taken.

Interestingly, a quite separate theme of 'accountability of the regulatory body' also emerged from the focus group discussions, as is evident from the following quotes:

> *"It is also important that the persons evaluating and regulating the required skills and competencies should also be competent, skilled and knowledgeable; the chairperson of regulatory body should be committed to provide quality of service and welfare of the society." (FCGM8)*

> *"But the Pakistan Medical and Dental Council, itself is under a lot of criticism. There are allegations of bribery, corruption, victimization and favouritism. The*

> *regulatory body itself should also be accountability to the professional community, the public and the Government." (PMAM5)*

The participants believed that accountability was only possible if there was implementation of the rule of law. As stated earlier, regulatory bodies and individual institutions as well as the government establish laws and policies on the code of conduct of health professionals. In the absence of implementation of these rules and laws, accountability is impossible and the trust of the public in the profession is eroded (Chandratilake, McAleer, Gibson & Roff, 2010):

> *"If a doctor don't do good operation or misguides the patient and government punishes him and other doctors protest against government and claim that, that doctor didn't do anything illegal and other doctor says that we are with that doctor and establish favouritism. But other doctor should think that this doctor has done illegal task and he should be punished as it has placed a black-spot on the medical profession. In our society, it also exists that expired patient are taken [to clinics & hospitals] and then doctors are blamed for the death of the patient." (NRIF10)*

Another participant from the focus group discussions involving allied health sciences, on the implementation of the rule of law, states:

> *"If there is no accountability, if laws are not followed or implemented, then professionalism cannot be improved."(AHCF3)*

In the absence of 'implementation of the rule of law' medical professionalism, teaching, training, assessment and accountability cannot be upheld (Dixon-Woods *et al.,* 2011). One allied health sciences student remarked on the lack of regulation leading to unprofessional behaviour as follows:

> *"There is strictness; they have rules and regulations; no one takes bribes. Here they take." (AHBM5)*

Significant structural changes to medical regulations, in particular the introduction of revalidation in 2012, have resulted in a new wave of accountability and regulation across every aspect of the profession in the UK (Bryce et al., 2018). This has resulted in

the emergence of a new group of doctors, a hybrid group responsible for making periodic recommendations about the ongoing fitness to practice medicine of all other doctors in their organization. These hybrid doctors, the regulatory officers, are emerging as the new champions of accountability and professional regulation within the community of practice.

Respondents in our study repeatedly confirmed the importance of accountability:

> *"Accountability is very important because human nature is such that if we are let loose, we follow our own path. So, that is probably, the God has created a chain of commands also and it is always there. That punishment should be there and 'reward' should be there in the form of whatever the rules are set in. And I think, in a society where accountability is more those societies are better than those where accountability is only for the few." (FCAF13)*

Accountability is however difficult to establish especially in developing countries where self-interest and politics frequently come in the way of accountability, as one faculty member in our study noted:

> *"I've noticed that in every field, not only doctors but our generals, our politicians, our bureaucrats, the law is broken by upper hierarchy. They let it loose for their personal gains or whatever their petty interest is. So that's why external accountability is very important. That should be maintained strictly." (FCAM10)*

Participants frequently referred to how the culture of accountability by peers and seniors that existed at the workplace is vanishing leading to an environment in which every professional feels free to bend rules at his convenience. Referring to just this one faculty member stated:

> *"I think punishment has its value more than reward, our accountability has been finished. In previous days, you are to reach in hospital at 7:30 and you reach 7:35, someone asks you" why you come late?" But that culture is no more." (FCDM7)*

In Pakistan, as in some other countries in the world, professionals hold a regular public sector job but are allowed to practise privately in their own clinics or group practices. There is a huge difference in the cost of these two services, the public service being virtually free at the point of care for the patient. Participants in all the groups generally believed that

professionals behaved more responsibly in the private sector than in the public/government sector. Participants believed that market values were driving the professional behaviour of the healthcare provider in that they behaved more professionally and provided more patient-centred care where they were getting more financial benefits. One faculty member stated:

> *"In private sector, you are to be more competent and compete with the rest of people and we cannot say certainly to get out. But in government departments, we are sure that no one can get me out of my job till retirement whether he will work or not. I don't remember that most of our extraordinary teachers would get reward for their good service. There should be feedback and accountability. I will be more conscious if someone is watching and observing my deeds. If I think I am not accountability , I will not be so much responsible. In private sector, after serving even five years, you are to get training and you should know the latest techniques, knowledge and skills. If only two doctors behave ethically and ten doctors don't behave ethically, we should start system of evaluating doctors and assess them and give these doctors reward, in this way other ten doctors will behave ethically." (FCIF13)*

A person who exposes any illegal, unethical, corrupt or improper activity in any organization whether private or governmental is called a 'whistle-blower'. Whistleblowing as an act of exposing activities like those mentioned above are part of the accountability that individuals hold others responsible to in any society. This, as an act, is a last effort in most cases by individuals who have witnessed illegal or corrupt activities and see that these are not being reported intentionally or unintentionally. In the healthcare sector, medical errors and cases of negligence may very well be unearthed by whistle-blowers. Jubb (1999) points out that:

> "Whistleblowing is characterised as a dissenting act of public accusation against an organisation which necessitates being disloyal to that organisation. The definition differs from others in many ways but especially by its emphasis on dissent, by being based on the ethical dilemma of conflicting loyalties, and by the strict way that dilemma is formulated in terms of confidentiality and proprietary rights over information. These features result in a definition in which motive has no part, and which requires a free choice decision to make disclosure to an external party" (p.77).

The UK *Consensus Statement* recommends whistleblowing as a core topic in the curriculum in undergraduate medical education (Goldie, Schwartz, McConnachie & Morrison, 2003). However Rennie & Crosby (2002) argue that little is known about the attitudes of students and their potential behaviours related to whistleblowing on account of very few evaluation studies having been undertaken of the curricula that incorporate whistleblowing. Goldie *et al.* (2003) conclude that whistleblowing must be addressed as part of the wider domain of professionalism. They argue:

> "students should be encouraged to contemplate dilemmas from all ethical stand points and consider all relevant legal implications" (p. 386).

Rodulson, Marshall & Bleakley (2015) remember a time when whistle-blowers were excommunicated by the community of practice of healthcare providers. Whistle-blowers did what they did in the larger interest of the public and indeed of the community of practice as well. But they were seen as the enemies of the profession. This no longer holds true. Today the public, the community of practice, the government and the regulatory bodies embrace these whistle-blowers as saviours of the profession. In Australia whistleblowing is now described as a healthy example of virtue ethics in practice (Jefferys & Faunce, 2007). Similarly, respondents in the focus group discussions referred to the act of whistleblowing in order to expose unwanted or unethical, unprofessional behaviour on the part of the health professionals, an important aspect of professionalism itself, as is evident from the quote below.

> *"Professionalism requires that one does not do unprofessional behaviour himself and when he sees others engaging in it, he reports them to the right authorities." (PMAF5)*

The participants in the study also recognize that doctors' treatment records influence how they are seen in terms of being professional. They argue that professional respect comes only partly from ethical behaviour, it also comes from being successful in treating patients. They

add that they would prefer to present themselves in case of illness to a healthcare provider who is reputable, that is, one that has a certain repute in the community of practice:

> *"...dealing appropriately with the patient listening to him patiently and having a high success rate of treatment." (FCGM 3)*

Askew, Lyall, Ewen, Paul & Wheeler (2017) in an Australian study emphasise the importance of patients' perceived confidence in the healthcare providers on outcomes of patient-health provider encounters. That professionalism requires a doctor or health care provider to meet up to the expectations of the patients in terms of his technical skills, thereby establishing a repute for safe and technically sound doctor, is not a new concept emerging out of this study. In fact, the writings of Hippocrates in 320 B.C. titled, *Requirements for a physician* refer to this frequently (Campos-Castillo & Anthony, 2019). One of the respondents in this study refer to it as:

> *"Treatment of a doctor makes him good. Number of successes counts a lot. Patients normally discuss with each other that this doctor has treated a large number of patients successfully. Treating such a large number of patients develops the goodwill of doctor and then patients will consider that doctor good." (PTAM2)*

In the eyes of the patients, the success of treatment by a physician builds his repute especially when combined with an attitude which is not heavily inclined towards monetary benefits gained from patients. Government sector hospitals in Pakistan are there to provide optimum care free of charge to the public. In the focus group discussions participants note that healthcare providers deal with patients less satisfactorily because patients are of no financial value to them in these public hospitals. On the other hand, in their private clinics the same health providers provide a more satisfactory consultation and treatment.

> *"Doctors treat differently in government and private hospitals. In private hospitals doctors check and treat properly, whereas in government hospitals they don't even bother to talk to us. In their private clinics patients represent financial benefits. I*

think the practice of medicine is largely influenced by greed these days. " (PTAM12)

Self-accountability:

The external accountability through regulatory bodies and a force of regulatory officers does not in any way mean that practitioners are no longer expected to regulate themselves by practicing in accordance with shared professional standards (Waring, 2007). Thus the importance of internal accountability also cannot be denied. Chandratilake *et al*. (2010) stated that the public in the UK expects doctors to be confident, reliable, dependable, composed, dedicated and accountable across all settings. With challenges facing professionalism in the area of external accountability highlighted by the participants of the discussion groups above, they noted that internal accountability assumed greater importance if professionalism is to be safeguarded and propagated. As one of the discussants remarked:

"When we are six to seven years, we know the ethical values, belief system and culture but with the passage of time we don't follow those values as we see other people not practicing these values. The people who have strong belief system only follow these ethical values." (FCBM12)

McCulloch (2006) thought that within the hidden curriculum of the working clinical environment the requirement to follow institutional policies and rules of regulatory bodies in patient management frequently comes into conflict with various environmental and contextual factors that can lead ethical students and junior doctors to commit unprofessional behaviour over time during medical training. These may include behaviours like falsifying medical records because of the shortage of time. These behaviours once initiated and established are carried over into the professional careers eventually leading to disciplinary action if and when caught.

Carrese *et al*. (2015) state that in the United States of America, there exists a movement to assert the need for professionalism and to assess the humanistic and ethical foundation provided throughout in the educational continuum of medicine. Self-accountability forms an integral component of this training. One of the physicians from the focus group discussions stated:

> *"I have observed the attitude of 1st and 2nd year students; their attendance is different from students of 3rd and 4th year students. We as a teacher must see our fault. When students are in 1st and 2nd year they are more but in 3rd and 4th year they become less. What is the reason? Teacher should see his behaviour. When students come in 1st and 2nd year they are taught with strictness but when they are in 3rd or 4th year they are relaxed and become less. We must see why it is so? If a teacher is made in charge of 50 students of 1st year then if a student is not present it should be checked why he is not present. If in a class of 350 only 70 are present where the others are? There must be relationship between teacher and students. One person should be there to have an eye on them." (FCKM7)*

An Allied Health Sciences student succinctly sums it up as:

> *"When you have autonomy, you also get liability that you have been given a responsibility." (AHCF3)*

Another very interesting theme from the focus group discussions of various stakeholders argues for accountability by status. The physicians as they progress in their career have greater responsibility to uphold the basic tenets of the profession. If the rewards and incentives, honour and prestige increase with time spent in the profession, the accountability should therefore also be more demanding with the rising seniority of the professional. This is evident from a quote by a policymaker:

> *"The profession and professionalism is only going to heal if doctors are held responsible and accountable for their actions. The more senior a professional, the harsher and stricter should be the accountability." (PMAM5)*

In an interesting Canadian study, Chinzer and Russo (2018) identified that employers also looked for soft skills, including attention to detail, responsibility, time management and

teamwork amongst others at the time of offering employment to graduates. O'Reilly, Chatman & Caldwell (1991) proposed the importance of 'attention to detail' including precision of work and rule orientation. This commitment to attention to detail is referred to by various stakeholder groups as part of professionalism. A quote illustrating the point is reproduced below.

> *"Whatever the duty is assigned to you complete it with skill, proper timing and with full devotion and responsibility." (AHDM1)*

This commitment to attention to detail requires professionals to attend to minute details of one's professional commitments with responsibility and a sense of duty as is evident from a quote from faculty member's focus group discussion:

> *"We are all emphasizing one aspect of professionalism that is ethics, but professionalism is not only ethics. Professionalism requires a person to be dutiful. It is not professionalism to come late and not to attend patients of outdoor, keep on talking rather than performing assigned tasks, eating food and taking tea in multiple times or not teaching the students, not to follow time table scheduled for us. These parameters are more important than ethics. I know teachers who were principals and didn't miss the outdoor and indoor patient and they were more professional." (FCCF5)*

Sattar, Roff & Meo (2016b) in their article on similarities and variances in the perception of professionalism among Saudi and Egyptian medical students found that students identified lack of punctuality for classes as unprofessional behaviour. Echoing the premise proposed by Stern & Papadakis (2006), that unprofessional behaviour during the training, if unchecked, leads to its manifestation in the professional career later on, one medical student remarked:

> *"A doctor should be responsible because he is dealing with the life of a human, but in other profession he will not get such chance of serving mankind and saving lives of human beings. A doctor should be punctual and regular." (MSJM1)*

Barilan (2009), in his article on responsibility as a meta-virtue, argues that truth-telling, deliberation and wisdom in medical professionalism form the new discourse on medical

professionalism and responsibility. He looks at the discourse through the lens of moral value conflicts, especially related to truth-telling. He argues that responsibility of care is a second order value. Responsibility of care corrects laws, virtues and norms in some cases. To exhibit responsibility of care, the commitment to give priority to the good of the patient over one's own good is required as one of the fundamental duties of the profession.

Barilan (2009, p.155) argues that keeping the interest of the patient foremost "is the special responsiveness to the need of the sick". He further argues that it might always not be possible to place the interest of the patient above the interest of self. He proclaims that "a better formulation would be that the good of the patient, particularly the substantial good of the patient, takes precedence over the minor goods of the doctors" (Barilan, 2009).

On acting in the best interest of the society/patients one of the doctors remarked:

> *"To health professionals, the interest of the public at large, that of the society and the nation as a whole is of paramount importance. We realize that our sole objective as a professional is to look after the health-related interests of the society in which we practice regardless of whether we receive monetary incentives or not. We should recognize that this will not be always easy, but this is what is required of us." (FCBM5)*

The structural framework emerging out of the FGD in the current study fails to cleanly dissect ethics from other aspects of professionalism. Responsibility is as much a part of ethics as ethics is a part of responsibility and its components.

Recognizing responsibility to profession/ community of practice:

Self-accountability and acceptance for accountability is only possible if the health practitioners truly understand the responsibility the community of practice places on them. On understanding the responsibility placed by the community of practice, one of the medical students of the focus group discussions stated:

"Yes! With the passage of time you would be aware about "what profession demands from us?" Our behaviour and values will definitely change." (MSGM7)

This duty to the profession in one's commitment, motivation and devotion is reflected in the following quote:

"Sir, when we use the word 'saver' then it means we have to forget ourselves even after our duty hours. During our duty hours we serve for salaries, but if we find anyone injured on roads, in our society or even in our neighbours we ignore at time, so this thing should not happen. Professionalism is that we must use our profession our duties and our skills wherever they are required." (NRFF3)

Functional and pro-active associations of health professionals were also seen to enhance professional commitment amongst their members as reported by Veloski & Hojat (2006). Jaeger (2009) supports the viewpoint that health professionals can do much better work by increasing their commitment to the profession and professionalism. He argues that health professionals are already doing a whole lot right. He too acknowledges that an association with a professional body improves commitment to serve and work.

The participants in our study also referred to commitment to one's profession as an integral component of medical professionalism. On 'Commitment' faculty members stated:

"Professionalism in any profession is the commitment, devotion and dedication of a person to his job/profession." (FCAM5)

"Imbued with the determination to serve the profession by every means possible." (FCBM12)

One of the medical students stated:

"There are many medical colleges who are just teaching and there is not any practice of them so they can't perform properly. This is very big thing in medical profession. Those people are doing who are not committed. This is another thing that you are a doctor and doing a job from 8-5 so you have to be committed you have to work well there." (MSAM1)

Another remarked:

> *"He must show good and gentle spirit, his behaviour must be swift. He must take his profession serious[ly] and must be hard working. He must be sincere to his profession." (MSFM3)*

Berwick (2016) considers that perhaps it is not accountability and professional regulations that portray the true picture of medical professionalism but rather the willingness and commitment of healthcare providers as a community of practice to do their best, one patient at a time. He continues to argue that to be able to do this in a time when social divisiveness dominates virtually every aspect of social life will be pretty remarkable.

The participants in this study also referred to this socially related desire to promote self as superior to others in the community of practice for various gains including but not limited to financial in nature. They refer to various social challenges perhaps inherent in eastern cultures within developing nations that dictate the way health professionals sometimes behave. One quote from a medical student on embarrassment to seek advice from peers and seniors illustrates this point:

> *"The doctor who is treating at private clinic may say to the patients that "other doctor cannot treat you well", because doctor in private clinic would get more revenue and livelihood by telling patients wrong about other doctor and will advise to come to him or not to go to other doctor. We don't consult from other doctors as we think this patient has come to me so I should treat him even if we are not understanding the disease. We should adopt such environment in which we should consult with seniors as well as juniors. We hesitate and feel embarrassment for consulting with juniors. It is very bad code of conduct for a doctor to develop and tell wrong perception about another doctor for monetary benefit. In Islam, even you are better than other doctor; you should not tell about the faults of other doctor to patients." (MSEF13)*

Further emphasis on the role of company and the social pressure to blend in and be like the rest of the community is provided in this remark by a medical student:

> *"Social company of the students also have an effect on their behaviour. In Islam concept of good company exists. "Man is known by the company he keeps". In case of addiction the doctors suggest that the patient should not go back to that company*

> *of addicts. Same is the case with the professionalism, if the behaviour of all the colleagues is good the newcomer would also behave well and if colleagues' behaviour is bad the newcomer behaviour would definitely be bad. The existence of role model should be there." (FCDF4)*

Shapiro, Nixon, Wear & Doukas (2015) state that the formation of the medical professional requires three important commitments from each physician. First comes adherence to rigorous and accountable evidence-based medicine that establishes competence. Secondly physicians use this knowledge and skills to promote and protect the health-related interests of the patients above that of their own; and finally an adherence to knowledge, skills and virtues of medical care which they also entrust to future generations of physicians again keeping the interest of the profession and public above their own self interests. These views are shared by Doukas *et al*. (2013) and Page (2006).

Honesty is at the heart of any kind of responsibility; honesty strengthens self-respect (Barilan, 2009). Stern & Papadakis (2006) present a continuum of dishonesty if left unchecked as follows: a student who cheats in exams leads to a medical clerk who copies residents' notes leads to a doctor who deceives the insurance agency in covering a test. Honesty therefore is an important component of an honourable doctor who is true to the code of conduct and follows policies. Honesty is a virtue that falls under ethics but at the same time it is a deliberate action required of a professional.

> *"Not being attentive to the requirements of the profession is also dishonesty, a dishonesty to profession and professionalism. An honourable, honest doctor, dedicated to profession and its values believes that he will be respected by his own conscience and by others only if he is seen to exhibit an honesty of purpose at work. " (FCAM5)*

Ben-Bassat (2019) from Israel reflecting on the subject states that the students' distress is related more to the clinical learning environment than to the personality traits of the students and also that development of medical professionalism attributes is

arrested during medical training in undergraduate years. At the same time the participants argued that it is very difficult for a health professional to stay honest and incorruptible. The society they believe respects professionals that are seen to be belonging to a certain social higher class. Society judges the competence of the professional on the basis of the money he has, the car he drives, the clothes he wears and the power he exudes rather than on other virtues that are related to professional behaviour and technical competence. A faculty member comments:

> *"If some doctor will come to hospital or clinic by bus, the patient will say that this doctor comes to hospital by hanging on the bus. It is societal norms, the successful person would have good vehicle, good clothes and standard house. Society gives value to a person on the basis of money and no one is asking from which means money is coming. Society values are developed in a way that an honest man would have to adopt wrong means and ways to make him standardized doctor." (FCBF5)*

Youssef, Peters & Youssef (2016) in a study in the Caribbean identified that there exist two distinct groups of professionals, one that still clings on to the self-sacrificing, altruistic values that define traditional professionalism and another that believes in doing just enough to stay above the public and regulatory body scrutiny while serving their own needs and requirements for a better quality of life. The participants in this study, however, believed that a health professional should be honourable in his conduct.

> *"A professional should behave honourably. I mean when we talk of him we can proudly say that he is an honour to our profession." (MSDF5)*

One of the patients talking about following policy by doctors complained that especially in public sector hospitals healthcare providers neglect to follow policies of the institutions or the government that have been developed in order to safeguard the public. This they believe is done with the deliberate intention of profiteering at the expense of the patient:

> *"Another thing I want to share is that doctors suggest lab tests from outside the hospitals, even in hospitals there is facility of lab tests. They have financial relationships with these labs and are paid handsomely for referrals." (PTAM1)*

Pavlica & Barozzi (2003) argue that sincerity of purpose in the discharge of duties is required of professionals. This sincerity of purpose should transcend every aspect of his or her professional life. An honourable, dutiful, honest, devoted, motivated doctor will certainly earn the respect of the society in general and the community of practice in particular. In order to earn respect, one is required to give respect. One of the patients complained:

"Doctor says, 'Shut up and get out'." (PTAM1)

The profession through its community is required to espouse a sense of service to the profession, thus taking professionalism seriously and avoiding internal bickering and conflicts that erode the community's image in the society (Berwick, 2016).

"I think professionalism includes sense of responsibility, knowledge, skills and your own ethical and moral values. For example, if a doctor leaves without giving charge to newcomer doctor, it is not professionalism. If a doctor who is general practitioner treats the patients who are desired to be treated by the specialist doctors, it is not professional behaviour. By being general practitioner we should send the patient to the specialist who would treat him [in] a better way and would behave more ethically." (FCIF7)

Another attribute identified expected medical professionals to be moderate and sparing extending leniency and tolerance in their inter-professional and physician-patient relationships. Berwick (2016) argues that one of the ways to develop trust in the medical profession within the public is through portraying an image of collaborative, cooperative team work in which reliance is placed on the expertise of team members in solving individual and group problems.

"They should be able to effectively communicate their problems to their peers and to their seniors. Ask for advice." (PMBM4)

'Societal awareness', 'societal empowerment', 'patient empowerment' and 'societal education' were different terms used by many participants in focus group discussions to refer

to ways to strengthen medical professionalism by holding health professionals accountable for their knowledge, skills and attitudes:

> *"Sir, awareness is also important as they do not know what is better for them." (AHCM2)*

> *"You can also teach the public rather than doctors that what their rights are." (NRHF),*

> *"Unless we teach the society, educate it, so that they understand their rights, doctors will continue to behave unprofessionally." (FCMM5)*

> *"If professionalism is to flourish then society needs to be educated. It is the responsibility of the community of practice, the government and individual professionals to educate the society. This in turn shall improve practice." (PMAM4)*

The community of practice of health professionals extends throughout the globe and health professionals are a worldwide commodity. There is frequent and extensive movement of health professionals from one country to another and within the same country as well. Situation, context, environment at work and patient expectations vary greatly even within the same country with changing locality and context. Tolerance, flexibility and adaptability to changing situations and contexts have been defined as a function of medical professionalism in the focus group discussions. Day (2002) concluded that physicians had a higher tolerance of uncertainty than previously attributed to them in the literature (Seys *et al*., 2013).

Hendelman and Byszewski (2014), in a study in USA, while categorizing lapses of professionalism, explored the formation of medical student identity in the learning environment and concluded that medical students regularly witness lapses of medical professionalism by peers and faculty members that have an influence on the development of their professional identity. It is not difficult to understand the strong connection medical professionalism has to a positive, morally and professionally correct health professional's identity. Bebeau (2002) also refers to the development of a strong professional identity as a

pre-requisite of sound medical professionalism. Wilson, Cowin, Johnson & Young (2013 p.369) from Australia in a paper that 'examines contemporary literature on the development of professional identity within medicine' propose the inclusion of identity along with competency in the definition of professionalism. They also seek to shift the focus of training to 'being a physician' instead of 'doing the work of a physician'.

Referring to this theme, one of the medical doctors remarked:

> *"In many ways you become what your profession demands…..you develop an identity that reflects your profession……and in some way you reflect on the identity of the profession as a whole." (FCAF4)*

Commitment to this profession demands a pledge to serve the profession and humanity at the highest standards contextually, culturally and in whatever situation necessary without prejudice and grief. On loyalty, one of the faculty members said:

> "There is no loyalty left to your country or profession or even your own kin and blood relations. We no longer teach loyalty to our students. What's it like to be loyal to your profession? The profession and its ethics are the most important stuff for you, but no one cares anymore." (FCGM2)

The following quote from a medical student in the group highlights this predicament:

> *"At present you just pay and get degree to be a doctor." (FCAF3)*

A large body of literature stresses the governance role of health professionals and relates it to their professional identity (Ferlie, Fitzgerald & Wood, 2000). In the United Kingdom, doctors are required to revalidate their licence to practice through an appraisal of information including governance data (Chamberlain, 2015), usually every fifth year (Archer, de Bere, Nunn, Clark & Corrigan, 2015). Marrero, Bell, Dunn & Roberts (2013) in a US study describe comparable schemes existing internationally. Not surprisingly then participants of focus group discussions in this study also identified core concepts of governance as emerging themes within their discussions:

"If you want to change the wrong practice, you have to start with yourself." (MSCM4)

Summary of subtheme RESPONSIBLE:

An important component of professionalism identified is accountability which is culturally non-existent in the country yet was highlighted by all stakeholders in the research study as one of the most important aspects of professionalism in consensus with the literature evidence. Patients in particular voiced their opinion that stronger mechanisms of accountability will lead to improvement in patient safety statistics. Self-accountability was promoted by the participants. Moreover, commitment to the profession was seen as an enabling criterion that promotes professionalism and counters the forces of commercialization.

4.4.3. Summary of ADEPT

The superordinate theme ADEPT, thus, consists of a number of constructs and a host of attributes that are related to the direct technical function of the professional. By and large they relate to the technical competence of the professional and his ability to function as a safe and competent member of that profession. Every profession possesses a certain set of skills unique to that profession. In relation to medical professionalism, every health professional is expected to possess these profession-specific skills up to varying levels of competence as determined by the profession itself. It is the acquisition of these skills that allows an individual to enter into that community of practice. This point was highlighted by the participants and validated by the evidence available in the literature.

The participants believe that these skills give the professional certain powers over others as a right to practise on others. However, this right comes at a price of self-accountability and subjecting oneself to external accountability. The literature and the

participants argue that a professional needs not only to exercise these profession-specific skills but also to be responsible enough to exercise them with the good sense to ensure the best outcomes for his/her clients, colleagues, society at large and the profession in general. The power that the profession gives comes with great responsibility which needs not just be recognized but exercised in every possible way. Only then can one fulfil the requirements of professionalism. The participants from the patient stake holder group in this study were willing to give up many of their rights that western society and medical culture takes for granted. At the same time it was observed that the doctors approached their notions of professionalism from a point of view that extended lesser autonomy to the patients. This may again be a very cultural difference in how professionalism plays out in practice between this region and the West.

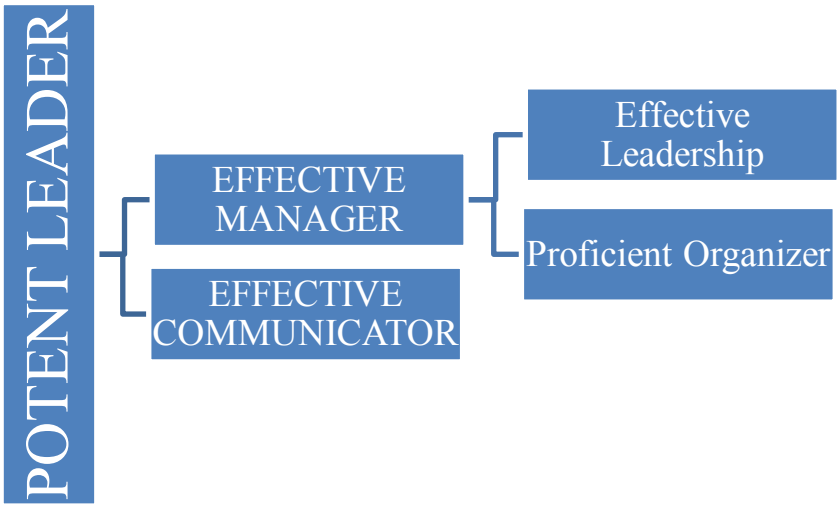
4.5. Theme 3: POTENT LEADER

"Professionalism is all about good leadership." (PMCF6)

Another superordinate theme identified, the third in the list, is POTENT LEADER. Our participants believed that professionalism requires qualities of leadership. A professional is required to have the power to accomplish tasks and to manage, organize and convince peers and patients alike: for this, certain attitudes, sets of behaviours, strengths of character and an ability to communicate effectively are required. A leader establishes trust (Tschannen-Moran, 2009), displays confidence, brings change for the better and sways opinion based on strength of argument and by leading through example (Hiton & Southgate, 2007).

Pawlina *et al*. (2006) argue that professionalism and leadership skills are essential for all healthcare workers. Clark, Spurgeon & Hamilton (2008) consider leadership qualities and competencies to be an essential ingredient of medical professionalism. Our participants believed that leadership encompasses both good management and effective verbal and non-verbal communication. Thus, falling within this superordinate theme are the two subordinate themes of *'EFFECTIVE MANAGER'* and '*EFFECTIVE COMMUNICATOR.*'

Figure 4.6: Superordinate Theme: 'POTENT LEADER'



As one participant on the subject of *EFFECTIVE MANAGER* stated:

> *"I agree that health facilities in Pakistan lack resources, some more than others, but then it should be the quality of his professionalism that he manages resources, uses his position in a fair way to motivate and encourage the community to contribute to institution building and resource provision and seek resources from the government and non-governmental organizations both". (PMAM1)*

While another participant had the following to add to the discussion on *EFFECTIVE COMMUNICATOR:*

> *"There may be a patient who will say to doctor, "I know nothing about my disease and you are all for me and provide me treatment whatever you suggest" and doctor behaves with him differently and there may be a patient who is literate who has searched the internet about his disease and will ask from doctor, "What is my diagnosis" and will ask "Would this medicine be fit for my health?" So, it is not possible for a doctor to evaluate the literate and illiterate patient in the same way and our response will vary from person to person. Internationally, it is being practiced to tell everything to the patient but in our society attendees of patients advise to doctor not to tell anything about the disease of the patient to the patient" (FCCM10)*

The two subordinate themes of *EFFECTIVE MANAGER* and *EFFECTIVE COMMUNICATOR* shall be presented next.

4.5.1. Subordinate Theme: *EFFECTIVE MANAGER*

Goss, way back in 1963, identified hospitals as one of the finest examples of professional bureaucracy (Goss, 1963). Embedded within this identification is the managerial role of the health professional. Noordegraaf (2011), Reay and Hinings (2009), Currie, Lockett, Finn, Martin & Waring (2012), Muzio & Kirkpatrick (2011), O'Reilly & Reed (2011) and Thomas & Hewitt (2011) all state that professionalism is affected by changing organizational context and cases. They believe this is creating professional-managerial

hybridization. Kirkpatrick, Hartley, Kuhlmann & Veronesi (2015 pp.325–340) also identify the increasing trend of health professionals performing hybrid management roles in order to fulfil the need of improving the governance of healthcare service.

Interestingly in the current study participants of various focus group discussions were frequently found relating to this hybrid professional-managerial role of the health professional.

This subordinate theme of *EFFECTIVE MANAGER* comprises of two components: *Effective leadership* and *Proficient organizer*.

Effective Leadership:

> *"An effective leader leads by example, people trust his judgements and actions. A professional is an effective leader." (FCMM4)*

Fineberg (2012), writing on the American healthcare system, admits that the health profession supports the policy of acquisition of knowledge and skills that strengthen leadership qualities within a health professional. Frich, Spehar & Kjekshus (2015) in a Norwegian study in which they interviewed 30 clinicians in managerial positions identified an increasing awareness for the necessity of teaching leadership skills to health professionals. They commented that in Norway as in the rest of the world generic and tailor-made health professionals' leadership development programs are available. A majority of these focus on skills training and technical and conceptual knowledge.

Grus *et al*. (2018), reviewing "definitions from other health professions and how they address professionalism" (p.1) in relation to health service psychology in the US, state that recently there has been a shift in how professionalism is viewed by various stakeholders. It is no longer just an innate character trait but rather a sophisticated competency that can be developed and refined to strengthen the patient and health practitioner relationship and inter-

professional team efficiency; build confidence; build systems; and develop situational competence.

The effective leader was described in our discussions in terms of: being a team-player and believing in team-work, which includes the ability to build teams and delegate work; being a good role-model who leads by example; handling and taking initiatives which might challenge the status quo; being resourceful; and overcoming challenges with a positive attitude.

Scheele *et al*. (2008) in a study in Netherlands identify teamwork and the ability to build teams as an important pre-requisite to a successful teaching career and professional life. Leasure *et al*. (2013 p.585) in their review describe

> "a well-delineated set of teamwork competencies that are important for high-functioning teams and suggest how these competencies might be useful for interprofessional team training and achievement of patient-centered medical homes standards. The five competencies are (1) *team leadership*, the ability to coordinate team members' activities, ensure appropriate task distribution, evaluate effectiveness, and inspire high-level performance, (2) *mutual performance monitoring*, the ability to develop a shared understanding among team members regarding intentions, roles, and responsibilities so as to accurately monitor one another's performance for collective success, (3) *backup behaviour*, the ability to anticipate the needs of other team members and shift responsibilities during times of variable workload, (4) *adaptability*, the capability of team members to adjust their strategy for completing tasks on the basis of feedback from the work environment, and (5) *team orientation*, the tendency to prioritize team goals over individual goals, encourage alternative perspectives, and show respect and regard for each team member".

Hodges *et al.* (2011) identify teaching as a teamwork task. They base their claim on the fact that resident education requires teaching and learning at various locations and by different teachers. Being a team player therefore is an important attribute of professionalism. Similarly, Pan, Norris, Liang, Li & Ho (2013), aiming to formulate a professionalism

framework for healthcare providers at Peking Union Medical College (PUMC) in China, identify strong team players to be selected as plastic surgery residents.

Our respondents agreed with this view: they expected the health professional to believe strongly in teamwork:

> *"No one believes in teamwork anymore. Everyone feels that it's someone else's job. That is not how it should be." (FCEF4)*

> *"In the health profession an individual is but a member of a team. It is important that he understands his roles and responsibilities within that team and how they change from team to team and from situation to situation." (PMCM5)*

Building teams to effectively and efficiently manage tasks came up as well in this study:

> *"Professionalism requires building teams, defining roles, supporting team members and working within those teams to achieve shared goals." (PMCF5)*

Herr, Hanna & Restauri (2018) comment that

> 'the concept of physician character can be understood as the interplay between the practice of the care-related virtues, such as empathy, compassion and kindness, and cooperative efforts with non-radiologist health care team members, termed collaborative professionalism' (p.1497).

It is to this cooperative, collaborative professionalism virtue that participants of this study refer to in their discussions as is clear from the following quote:

> *"Co-operative is the word that comes to my mind when I think of professionalism. Like he is supposed to co-operate with seniors, juniors, allied professionals and hospital management in the care of the patient." (PMAF4)*

Within their understanding of leadership and teamwork our participants recognised that work and the work-force needs to be distributed and tasks will require to be delegated, as evidenced from the following quote:

> *"Working in a team is all about delegating work. You cannot do everything yourself. Delegation results in the patient managed best." (PMCF1)*

Also on delegating work, one of the participants in this study remarked:

> *"At times the only way to get through the job is to delegate work and ensure that it gets done. You have to trust your team-mates in doing the right thing." (FCJM2)*

An effective leader inspires through example and performance. He builds confidence in himself. He needs to be a role model that his team is willing to follow and replicate. Shakour, Yamani & Yousefi (2016) write:

> "….students learn professionalism from the stated curriculum and a hidden curriculum. The hidden curriculum means that students learn the actions by observing the clinical faculty" (p.1483).

Elhami *et al.* (2017) in a study in Iran identify that interns learn professionalism from their instructors by observing them and that this observation is neither planned nor systematic. There is no doubt then that being a good role model helps foster medical professionalism values in those that work with the health professionals. It is interesting that being a good role model was also identified as an emerging theme from the analysis in the current study:

> *"Yes, your juniors will follow your behaviour: if our behaviour with the patient is good, juniors will adopt good behaviour with the patients. If your behaviour is positive, juniors will show positive behaviour and vice versa." (NREF4)*

One of the problems in a developing country that the discussants referred to frequently related to the opposition to any change that leaders try to bring in order to challenge the status quo. The majority of the community of practice alienates itself from the change-manager and the change process. Dashti, Laakso, Niemelä, Porras & Hernesniemi (2009) in their editorial for *Surgical Neurology* discussed matters related to complacency in the neurosurgical circle within their own context. They argue that doctors are one of the most powerful groups that can lobby for change yet they are reluctant to challenge the norms of the society.

In our study, patients' expectations were seen as linked with societal norms and able to have a significant effect on the practice of medicine:

> *"But public opinion holds much worth. The patients outside your clinic will speak about you. Nowadays, people do not run after appearance."(AHAM2)*

On this subject, one of the participants in this study remarked:

> *"When head of our professional organization make the code of ethics, they also come from our community that this should be like this. Because definitely if you are doing so it will be opposed from the other side. Then how you implement that?" (NRFF6)*

Being willing to challenge the status-quo, to take initiatives and to change things for efficient and professional care of the patient are important aspects of being a professional. These were also identified in the focus group discussions in this study:

> *"In current scenario most of the patients are being treated in Urology Department, the hospital administration should increase the number of doctors to handle such 'rush' condition. If senior doctors are in less number, the administration of hospital should hire senior doctors. In our society, most people work in day timings, and doctors should be available at night timing to treat the patient who don't have extra time for their treatment in the day and become free from their duties at night. Why does Outdoor Patients Department (OPD) close at night? OPD should remain open for twenty-four hours, so that job-holders and their families can be treated without bearing abnormal cost. One senior doctor with two junior doctors should be available for treatment of patients who want to get treatment in the evening. Patients of surgery and operation should be permanently checked in a separate department and should not be treated in OPD and OPD should be for patients who come for general treatment. Every department other than OPD is remaining open for two days per week only and then you should compare such availability of doctors with the increase of population" (PTAM7)*

Interestingly enough, the participants of the faculty focus group discussions also supported these attributes as required in a health professional:

> *"To me it seems as if the doctors these days just follow through the motions. They are reluctant to take initiatives." (FCJM2)*

However, Ginsburg, Regehr & Lingard (2003) in a Canadian study identified that obedience and allegiance also rated highly in the decision-making process under healthcare-related workplace situations. In an Eastern culture specifically and globally as well, an

allegiance to the peers and profession and obedience to seniors and teachers still forms the bedrock of the orthodox hierarchical structure that medicine still maintains. In this study, faculty members in particular demanded obedience from their juniors and considered it their professional duty:

> *"Times are changing. Ways have changed. But in this profession we still expect juniors to be obedient to the seniors." (FCKM1)*

These views were reflected by the policymakers:

> *"We expect our juniors will be obedient. They will listen to their seniors and to the hospital management." (PMBF2)*

But, interestingly enough, not by the students or patients:

> *"No, we act like what we have learned or not just to follow our seniors. But we try to do better than our seniors." (NRAF10)*

Participants in this study recognized the importance of the ability to overcome challenges in the work environment. Frich et al. (2015) recognized the absence of training programs in these and related leadership skill development areas. Herr et al. (2018) remark that it is important that programs are developed that train healthcare providers in developing an attitude of handling and overcoming challenges efficiently. One of the participants in the policymaker group identified this attribute as:

> *"Positivity…I think is a hallmark of professionalism. He should face all problems with a positive attitude head-on." (PMBM2)*

Proficient Organizer:

This second component related to *EFFECTIVE MANAGER*, being a proficient organiser, was discussed in terms of the following aspects: good time and workload management and mmanaging resources effectively; good at planning and prioritizing; being task-and goal-

oriented and focused, practical and disciplined; maintaining work-life balance, energetic and fit; and able to adapt to varying situations and contexts.

In this study, participants of the focus group discussions identified the managerial role of the health professional as an effective organizer, an important attribute that forms part of his or her professional self.

> *"I always admire a professional who is able not just to organize and manage his work life but his home life as well." (PMBM1)*

Management of time, resources and workload came up as important traits of a health professional within these discussions. Muzio & Kirkpatrick (2011) state that managerial knowledge and competency is being increasingly identified as complementary to professional knowledge and competence. This managerial role requires amongst others, managing time, as is evident from the following quote:

> *"Yes I agree that there are so many patients and just that much time to see them, but then are we not supposed to be good time-managers." (FCEM1)*

One participant remarked:

> *I once had an internee from America. Ultrasound was to be done. She used to take 10 minutes in formalities prior to ultrasound and within the said period I used to attend three patients. So, sometimes you cannot let things happen in an ideal way" (FCHF6).*

Another participant from amongst the nurses declared:

> *"We can manage workload, we will treat the patients who are to be provided emergency treatment and after treating emergency patients we will treat remaining patients." (NREF4)*

On efficiency of management and work, one of the policymaker participants remarked:

> *"There are different levels of professionalism for different professionals, I know an assistant in a hospital who is so professional in her work she checks the patients and lay the patient on the stretcher and collects all equipment and medical instruments required for operation within 5 minutes." (PMAM3)*

In terms of managing resources, the healthcare delivery environment is an inherently stressed environment with a workload that often does not match the resources available, not just in the developing countries but in the rest of the world as well. Healthcare providers have to adjust to these stressful environments that often lack distributive justice and make the most of what resources and time is available to them. Hafferty and Tilburt (2015 p.345) suggest that

> "[although] patient and workload demands decrease as residents become more senior, it also is true that the majority of first- and second-year residents appear to be at peace within the structural conditions (patient care demands, duty hour limits, and residency vulnerabilities) of their learning environments. Why this is so is not clear. In the end, we cannot firmly conclude, given the data presented, that residents who violated the duty hour limits did so because of too many patients, patient/family demands, or issues of patient acuity/complexity—particularly given our assumption that such structural precursors were present for all residents, but particularly novice residents".

They add that healthcare providers over time master the art of managing these workloads and adapting to harsh working conditions that sometimes place overwhelming demands on the physical and mental capabilities of these healthcare providers. One respondent in the current study remarked:

> *"To efficiently manage the workload day in and day out is the bedrock of professionalism." (PMAM2)*

Keshtkaran & Moadab (2013) in a study in Iran argue that clinicians who are intrinsically motivated to manage their workload and are effective planners are more able and productive healthcare providers. In our study, an ability to plan well was also identified to be an aspect of the proficient organizer role of a healthcare provider as is indicated from the following quote:

> *"I would expect a good professional to plan his daily, monthly and yearly activities...rather his life's goals and progress very carefully. I think this a very important component of professionalism." (PMAM5)*

On being practical, task-focused and able to prioritise tasks in a heavily work intensive and time constrained environment of the healthcare delivery setup, participants of focus group discussions remarked:

> *"A doctor needs to be practical...have a concrete thought process, be able to make decisions that lead to sensible actions." (FCEF3)*

> *"I believe that a good professional is able to understand what is more important and who or what to deal first." (MSAM1)*

Currey, Massey, Allen and Jones (2018), gathering data at the Australian and New Zealand Intensive Care Society Rapid Response Team (ANZICS-RRT) Conference in July 2015, identified that the participants valued 'approach to the task' as much as knowledge- and skills-related competencies to accomplish a task. Participants in the current study, similar to participants in their study, appreciated maintaining focus and attention towards work and job as important aspects of professionalism. In their opinion, handling patients and completing tasks took precedence over personal and social activities while on the job:

> *"Too many tasks remain unattended while doctors focus on socialising in wards or just being uninterested." (FCLM3)*

Park, Shon, Kwon, Yoon and Kwon (2017) in a study in South Korea involving 109 first-year medical students identified that students valued a focused approach to patient management. They gathered anonymous accounts of instances of medical professionalism witnessed and reflections on their own professionalism contexts. In the current study participants desired that health professionals maintain focus while managing tasks and handling patients and avoiding being distracted as much as possible. They felt that a healthcare provider needs to be practical in his approach to patient care and work management. They felt that this too is a learnt trait that adds considerable value to a health professionals' approach towards his/her professional duties and their conduct:

> *"These days there are so many distractions, like people coming in without appointments, media, patient attendants, peer pressures, job pressures. He should be able to avoid all these distractions and just do his duty when it is time for duty." (PMCF3)*

> *"Professionalism is remaining to the point not getting all the problems at once, remaining focused on the problem." (FCEF5)*

On managing stress and maintaining work-personal life balance, one of the Allied Health Sciences students remarked:

> *"We need to keep professional and personal life separate" (AHAM5)*

Fitness came up as a very interesting issue in this current study, since the theme related not to fitness-to-practice but to physical and mental fitness as is evidenced from the following quote by an MBBS student:

> *"How can a doctor work properly if he is not physically and mentally fit? This is also part of professionalism and patients look for it in a doctor." (MSBF13)*

Maza, Shechter, Pur Eizenberg, Segev and Flugelman (2016) in a paper on physician empowerment programs in the Israeli context also recommend focused educational programs for faculty development that allow health professionals' empowerment and help them avoid burnout. Turabián, Minier-Rodriguez, Rodriguez-Almonte and Cucho-Jove (2017) in a Spanish study identify 'energy' as an important component of resilience within health professionals that allows health professionals to function efficiently, avoiding burnout under the demanding and varying conditions of the healthcare provision environments. Owlia *et al*. (2015) in the Iranian context support the need for training of health providers and their patients both to be resilient and energetic through targeted programs that helps them avoid burnout.

Hilty *et al.* (2015) describe a number of health professional training programs in the US that are based on mindfulness. Such programs have shown to decrease depersonalization

and burnout. These programs help health professionals handle challenges with a positive attitude, help them use environment to their own advantage while becoming more environmentally aware. This in turn helps in maintaining work-life balance, adapting to varying environments, to creating the right environment and the discharge of their duties. Such programs could help develop health professionals in the areas of cooperative and collaborative and goal-oriented working as is exemplified by the following quote:

> *"I call a person who sets goals and targets and makes plans to achieve them, then reviews and follows through and actually achieve those goals through hard work and dedication a professional." (PMAM3)*

Participants in our study identified the ability to adapt to varying environments of healthcare delivery as an important ability that promotes medical professionalism. Byrne, Loo & Giang (2015) in their US-based study call for an environment that is under the control of the healthcare providers who assume managerial roles in its modulation and management. They ask for greater flexibility and autonomy to be extended to healthcare providers, especially residents, in extending their duty hours at their will if they intend to commit to continuity of care of their patients or are willing to share workload. In this study also, participants were of the view that health professionals should be able to manage their workplace environment and use it to the best of their abilities to manage patients as best as they could:

> *"Then if the environment is not to their liking, they should take initiative and revamp it to their needs and requirements, or make the best of what is available." (FCJM2)*

Nesje (2017), in a Norwegian study, argues that when health professionals are placed in roles or environment that are not familiar to them it leads to stress and burnout. The study identified that the level of stress was less in those that were identified to have greater professional commitment. Jamal (2014) in a study in the Middle East Gulf States identified

that nurses with a high level of commitment and strong professional identity were able to mitigate the effects of stressful work environments and in fact to challenge the environment to extract the best out of it for their patient encounters.

In this study as well, participants were of the view that health professionals who were better at medical professionalism were more likely to adjust to varying environments easily. Not just that but they were more likely to use the environment as a resource to manage patients more effectively:

> *"A doctor should be capable to work under any environment and resourceful enough to use the environment to his advantage in the care of the patient." (PMBF2)*

Participants in this study went as far as to suggest that health professionals should be committed enough to create environments in the workplace that lead to efficient and safe professional management of their patients, adapting to varying requirements of differing patient-healthcare provider encounters:

> *"If we have a lot of patients and we think it is going to change our attitude or behaviour as a doctor you can't change it, you should not change your behaviour. Let me say in clear words you have to do justice no matter what is happening." (MSAM1)*

> *"Professionalism demands that one should create the right environment for each patient for the patient to open up to the doctor." (PMCM5)*

Summary of EFFECTIVE MANAGER:

The sub-theme EFFECTIVE MANAGER covers a large number of characteristics that the respondents in this study identify as crucial to their understanding of medical professionalism. They argue that a medical professional should be able to lead through example, manage and organize not just his/her professional life but personal life too in order to strike a balance between work and family life. They maintain that mostly it is the lack of

leadership initiative and good managerial skills that lead to avoidable medical errors. Decision-making and effective planning in their opinion are key to success for medical professionals. These claims by the respondents were found to be matched by the world literature on the topic, yet neither leadership nor professionalism is routinely taught or developed through formal or informal training in the Pakistani curriculum, which is worrisome in light of such overwhelming importance of the same identified here and in the literature. The immense workload and flexible accountability in this region maybe one of the reasons that healthcare delivery systems are not managed as well here as in the west. A culture that lends to a greater differential of power between doctor and patient allows doctors and policy makers to get away with poorer management blaming this on increasing workload in the presence of dwindling resources.

4.5.2. Subordinate Theme: *EFFECTIVE COMMUNICATOR*

Within the subtheme *EFFECTIVE COMMUNICATOR* fall attributes such as the ability to be specific and focused in communication; to use language that the patient can understand; to counsel effectively; to keep seniors informed. Non-verbal attributes were also mentioned: being appropriately dressed and projecting a positive image of self. Exhibiting the 'right attitude' for effective communication, conveying politeness, calm, patience and tolerance were linked to being able to gain the confidence of the patient.

Knowledge, skills and attitudes require a platform of communication to make a positive impact on patient care and patient satisfaction. Cruess *et al.* (2010) note that before the mid-1990's there was hardly any literature available on the topic of medical professionalism in medical journals. Communication skills and other attributes associated with leading towards effective patient-healthcare encounters were being emphasized but without studying all aspects of the same holistically. They state that since then medical

professionalism has been defined. The General Medical Council in the UK emphasises the importance of developing professional behaviours such as communication skills in students (Thistlethwaite & Spencer, 2008). Jha *et al.* (2006, 2015) in the United Kingdom, Hoffman, Shew, Vu, Brokaw & Frankel (2017) in a US study, Hafferty & Franks (1994) and San-Martín, Delgado-Bolton & Vivanco (2017) all identify effective communication skills as a foundation stone of medical professionalism.

Jha *et al.* (2007) in a qualitative study on perceptions of professionalism in medicine identified communicating effectively as an integral component of medical professionalism. In fact one of the themes out of the seven that emerged from their study, 'Demeanour', falling under the conceptual component of appropriate manner, included both positive (projecting appropriate image) and negative (rude, arrogant) behavioural components. Another theme in their study of doctor-patient relationships falling under the conceptual component of empathy included negative (poor communication) and positive (collaborating with patient, enhancing doctor-patient relationship, treating patients with respect) behavioural components. Yet another theme of compliance to values was based on behaving responsibly, reporting to colleagues and maintaining confidentiality as positive behavioural components. Communication-related attributes are therefore seen to cut across three of the seven themes in their study.

Communicating with Patients:

Ennis, Happell, Broadbent and Reid-Searl (2013) identify communication as an important attribute of clinical leadership. Their study confirms that those deemed to be effective leaders by their peers and patients have an ability to communicate with others that helps build effective working relationships and rapport. Effective communicators were

acknowledged as leaders within teams in another study by Abassi, Siddiqi & Azim (2011). Their findings are similar to the findings in this study.

San-Martín *et al*. (2017) in a study based in Latin America argue that as healthcare providers gain more experience, they normally tend to become better at information assimilation and at their ability to communicate effectively with the patients exhibiting empathy and care. Hafferty & Franks (1994) emphasise that all forms of curricula place a stress on communication skills or a lack of it, affecting medical professionalism profoundly. Brinkman *et al.* (2007) in a US study emphasized the importance placed on communication skills while gathering multi-source feedback on medical professionalism. Hoffman et al. (2017) cite the example of Indiana University School of Medicine where in 1999 a competency curriculum was adopted wherein students failing in communication skills were required to take remedial classes and exams.

Participants in this study placed great emphasis on the role of the healthcare provider as an effective communicator. One of the participants remarked:

> *"A doctor should communicate in such a way which is understandable for literate and illiterate patient and doctor should solve all the challenges which creates communication gap between doctor and illiterate patient." (FCCM4)*

Leffel, Oakes Mueller, Curlin & Yoon (2015) in a USA study pointed out that students may take a more patient-centred approach provided they feel confident in communicating effectively with patients. Part of the patient-centred approach requires communicating with patients using language that they can understand. Our respondents also recognised this:

> *"I am student and in our classes we are told to take history in patient's language. He will feel comfort and take care of privacy. We will try to sort out the problem of patient so that he could be comfortable and provide necessary things." (NRDF4)*

Zerfass & Huck (2007) emphasize the role that both verbal and non-verbal communication plays in enabling strategic leadership and innovative management. Communication management empowers physicians with the ability to perform tasks efficiently and evaluate patient safety through conveying a sense of confidence and ableness.

The relevance of non-verbal communication skills has been recognized as far back as the time of Hippocrates and perhaps even to the dawn of this profession. While verbal communication is an important determinant of the outcome of a patient encounter, non-verbal communication is equally if not more important in defining the patient-healthcare provider relationship. In a patient-healthcare provider encounter non-verbal signals by the healthcare provider like eye contact, posture, tone of voice, head nods and gestures play a pivotal role in how the patient perceives that encounter and complies with advice given during it (Vogel, Meyer & Harendza, 2018). Mehrabian & Ferris (1967) even developed a formula for the verbal and non-verbal effects of a message: total impact = .07 verbal + .38 vocal + .55 facial.

The importance of non-verbal communication was equally stressed by respondents in this study. One of the members of the policymaker focus group discussions sums it up in the following quote:

> *"How a doctor behaves with the patient is important. I think a lot gets conveyed by the first encounter with the doctor, how he greets the patient, addresses the patient and his companions, the gestures and tone of voice he uses and especially the eye contact and facial expressions. Body language is important…patients may think that a doctor who is just hurrying along his duties because of workload is just not attentive enough or interested enough in their problems to open up to the doctor completely. Communication is the basis of the medical profession and non-verbal communication is just as important if not more in forging patient-doctor relationship." (PMAF2)*

Rowland, Coe, Burchard & Pricolo (2005) in a North American study also argued that both verbal and non-verbal forms of communication are important in developing the physician-patient relationship and in establishing trust. They noted that physicians from

Hippocrates to the 11th and 12th centuries CE frequently referred to acceptable images of physicians within their context, thus realizing a basic communication premise that in the event of conflict between verbal and non-verbal messages, the non-verbal message would be believed by both patients and colleagues. As evidence, they provide a passage from Hippocrates's writings:

> "The physician must have a worthy appearance; he should look healthy and be well nourished, appropriate to his physique; for most people are of the opinion that those physicians who are not tidy in their own persons cannot look after others well. Further, he must look to the cleanliness of his person; he must wear decent clothes and use perfumes with harmless smells. The physician must have a certain degree of sociability, for a morose disposition is inaccessible both to those who are well and those who are sick" (Rowland *et al*., 2005 p.214).

Duke *et al.* (2017) in a US study write that a physician's image is a mirror of competence, trust, expertise and compassion. Davies (2017) in another US study on communications skills in oral examinations pointed out that appearance affects attitudes. Rougas, Gentilesco, Green & Flores (2015) in their study on factors affecting the professional image of physicians showed three population groups across United States of America and Canada ten slides of physicians representing a variety of appearances, and different ethnic and religious affiliations. In their study, physician images that scored best contained a white shirt, traditional tie, dress trousers and leather belt, laboratory coats, tight leather shoes, little jewellery and conservative hair style. The physician images that scored poorest wore casual slacks, casual shoes, clothes with too many colours, stethoscope around their neck and unkempt hair. Their study did not show any gender or ethnic differences among respondents. They concluded that "a surgeon's image is a mirror of competence, trust, expertise, and compassion" (2015, p.901), a fact was realized even in the time of Hippocrates (Jones, 1923).

In the current study participants also identified that creating a positive image of self for society and patients is also important:

> *"It's all about the type of image he creates for himself and for his profession. What do people see in him as a professional." (PMBM1)*

> *I'd like to add to what doctor sb. said regarding this. He stressed on education, skills, and all these things of a profession. But I think we can also add the dress of a person towards official effects of professionalism. If he is not properly dressed and is not coming to the hospital in proper form, he lacks professionalism." (FCAM4)*

Being polite, patient, tolerant and calm:

Healthcare delivery environments are stressful and confusing especially for the patients and their attendants who are already stressed and anxious on account of the reason for visiting such an environment. The participants of the focus group discussions admired healthcare providers who can exhibit tolerance and patience under such conditions, as is evidence from the following two quotes:

> *"Both types of patients create problems….like some educated rich patients have their superior[ority] complex. They behave rudely and speak in an insulting tone because they are rich. But we have to tolerate all the things." (NRAF7)*

> *"Patience brings its own rewards. If we listen to the history patiently and are patient in all our dealings with the patient, we will be better doctors…more professional I mean." (AHAM1)*

Healthcare providers are expected by the patients to be polite and tolerant. They are required to develop good understanding with patients and attendants while staying specific and focused. Participants in the focus group discussions stressed the need for politeness conveyed through both verbal and non-verbal communication, while maintaining focus:

> *"Speak politely to the patients; give him proper instructions and procedure that what are you going to do with the patient." (AHDM2)*

The healthcare provider through his general demeanour, professional competency, patient handling skills and approach to patient problems and needs should be able to invoke a

sense of confidence in his team members, patients and other stakeholders in himself. On the subject one of the participants in this study remarked:

> *"His personality should be such and he should act in a manner that builds patient's and peer confidence in him." (PMCM5)*

Rowland & Kuper (2018) argue that patients do not visit healthcare providers to establish casual relationships. Proper communication skills, appropriately used, help gain the confidence of patients. They argue that effective patient management is only possible when a certain degree of confidence has developed between the healthcare provider and the patient. Confidence, they add, is a two-way street. This is mirrored in the following quote from a respondent:

> *"Besides knowledge, there is personal way that how you will convince other. Gaining confidence of patients and their families is crucial to compliance and effective treatment." (AHBF4)*

Regarding gaining patient trust and confidence, one of the study participants remarked:

> *"To avail confidence of patient is also professionalism." (NREF4)*

Patient counselling was identified both as an attribute and a requirement to be a health professional. This was also identified as an attribute in the focus group discussions:

> *"We should counsel the patient and should communicate well as sometime patient don't agree with the doctor's instruction and sometime patient's relatives don't agree to follow doctor's suggestions about treatment. So, doctor should communicate and counsel in a professional way. Patients expect to be informed what problem they have, the options available and any complications that could occur. Most of the time they want to take control of their journey through illness. They expect to be informed completely." (NREF13)*

On counselling and its rewards, one of the participants remarked:

> *"It [counselling] is needed to educate the patient, and to provide better health services to the patient only then I can expect that patient will understand in the same way as doctor is explaining and counselling." (FCCM10)*

Capable of engendering trust and respect:

Health professionals only very rarely work alone. Their job requires them to be effective members of teams. They move from one team to another frequently assuming varying roles within each. Campbell *et al*. (2010) emphasize trustworthiness and honesty among other things as key components of professionalism. In the current study, some of the emerging themes coming out of the analysis of discussions in the focus groups relate to these attributes of professionalism: loyalty and respect to peers, the profession and also to patients and their relatives, which engenders trust; and being seen as an honest worker.

Elhami *et al*. (2017) relate professionalism to the ability of the health professionals in Iran to gain the trust of peers and patients. The ability to build trust in themselves, not just amongst patients but also with other team members, is an important attribute of an effective healthcare provider/manager:

> *"Attitude towards patient is very important. Yes, if your attitude is good and you have more skills and knowledge to recover him from disease, the confidence of patient will be developed and trust will be built. Similarly, your colleagues look depend on you for team management of workload, your efficient work will build trust in you within them." (NREF4)*

Schlabach (2017), presenting a study in USA, described truth, honesty, loyalty and integrity as the topmost ranked core professional values by the participants. Working in teams and assuming managerial and leadership roles as healthcare providers requires them to exhibit these qualities or else the team structure will likely collapse. It therefore becomes important that a professional is viewed to possess these attributes by his teammates and they believe in the sincerity of these through his actions and not just by his words.

One of the participants from the policymakers' group in this study remarked on work ethics:

> *"There is something called 'honest worker'. He should discharge his duties to the best of his abilities, work with devotion and care and be punctual." (PMBM5)*

Core competencies for interprofessional collaborative practice: Report of an expert panel (Schmitt, Blue, Aschenbrener & Viggiano, 2011) declares that respect exhibited towards not just patients but peers and colleagues is a fundamental professional virtue. In this study, participants were of the view that healthcare providers should respect each other. This they believed would engender respect for the profession in the public:

> *"I feel that professionalism requires one to respect his community of professionals, something that we do not see these days. And what's more there is hardly any respect for what that community of professionals stands for or symbolizes." (PMBF4)*

Respecting patient attendants also was highlighted as an important aspect of medical professionalism in its fulfilment of the social contract.

> *"His family [patient's] has a right to be given proper respect." (MSAM1)*

Summary of EFFECTIVE COMMUNICATOR:

An effective communicator is a successful counsellor of patients on the one hand and maintains excellent work relations with his colleagues, seniors and other members of the healthcare team on the other hand. Medical professionalism demands that information is made readily available in proper time to seniors and supervisors to avoid blunders and to ensure that a collective decision-making process is established (Rowland & Kuper, 2018). On keeping seniors and colleagues informed, a respondent in the study from the policymakers group stated:

> *"I value a junior doctor that keeps his seniors informed about the patients. I think I will consider him a safe doctor, a more professional doctor." (PMBF2)*

Martin, Armstrong, Aveling, Herbert & Dixon-Woods (2015 p.378), in an ethnographic study of three English healthcare improvement projects, identify that many lapses in professionalism are the result of communication errors. They document that teaching communication skills is an effective strategy in medical schools that will help develop this skill early on. Rosenstein (2015) notes that unprofessional behaviour in medical practice can have detrimental effects on communication, teamwork, staff morale, patient safety, and quality of care. He goes on to add:

> "some organizations have taken a more proactive approach in trying to reduce the incidence of disruptive behaviours by providing specific training programs in diversity management, cultural competency, emotional intelligence, conflict management and/or additional training to improve communication and team collaboration skills" .

However, the quote below identifies grave misconceptions regarding communication two decades after the start of the medical professionalism movement. Musing on how the autonomy extended to the profession is sometimes misused especially in the wake of social contexts and cultural taboos one of the faculty members in our study remarked:

> *"I think the word 'Dant' (scold) is not perhaps right. You just tell and advise the patient in this way that if you are not cooperating with me how I can treat you. If it is in your benefit you may use harsh tone. I sometimes use harsh words on my children; it does not mean that I do not love them. We just give them a fear and do not use very harsh language." (FCFM10)*

4.5.3. Summary of POTENT LEADER

Leadership and communication skills were seen as integral components of Medical professionalism by the participants in this study, a claim that was validated by the world literature. It is not surprising that the world literature should abound with evidence linking both communication and leadership with professionalism and also for our respondents to think that way as well, since, after all, a professional that cannot communicate effectively with peers and patients and one that can neither lead nor manage can hardly be able to

practise his/her craft well. Nevertheless, there are cultural differences to the understanding of the role communication and leadership has in professionalism, especially the way it is used and exercised. The participants of the study largely argued for a more authoritarian and less inclusive model of leadership, a characteristic not well accepted amongst the leadership qualities in the western world literature.

Similarly, there were differences in the manner and nature of communication both verbal and non-verbal between the western literature and the participants that can best be attributed to cultural and socio-economic backgrounds. The patient stakeholder group in the study conceptualised a version of professionalism that extended a lesser degree of autonomy to the patients. They wanted to be told and directed rather than informed and guided. To them a paternalistic approach in all forms of communications was quite acceptable, rather sought out and readily accepted by the physicians for whom patient-centredness is still nothing more than a discourse.

4.6. Theme 4: SUPPORTED

> *"Attitude of doctor will always be same but ethical values may differ from country to country. The ratio of patient vary in government hospitals as compared to private hospitals; in private hospitals, there are limited patients and doctors behave professionally and give proper time to each patient and in government hospitals, doctors are overburden[ed] and they are unable to give proper time to each patient. Same doctor treats well in private hospital and same doctor goes to government and sees rush of patients and he gives less time to each patient." (MSJF4)*

Following an extensive iterative process involving analysis of focus group discussions of patients, medical students, nurses, allied health sciences students, physicians and policy makers a fourth theme, 'SUPPORTED' was identified. This theme gathers together the thoughts and experiences of participants which suggest that professionalism can only thrive and be practised within a properly supportive environment. Its main components relate to demotivation and burnout; job security; freedom from monetary concerns; progression opportunities and career structure; adequate resources; support structures within the society; and politicisation of the workplace.

An extensive search of the literature reveals that this issue of the critical nature of the supportive environment to the practice of professionalism has only recently been separately identified. This might be because, since the start of the medical professionalism movement in 1996 some 22 years ago, the majority of work in this area has been done in countries with established healthcare systems. In such countries, job descriptions, the roles of physicians and healthcare providers and the rights of patients are clearly laid down and already well-established. The current study is the first of its kind that includes a large number of participants from all stakeholder groups with the setting in a developing country. It therefore identifies explicitly and specifically the need to provide a support structure to the healthcare providers in order to promote professionalism.

This theme also sheds light on the issue of providing social, structural, monetary, peer-related support to healthcare providers within an environment that is constraint-free and in fact completely safe for the healthcare providers, as a means to strengthen and establish professionalism as a whole. Participants in this study on a number of occasions questioned the expectations of the profession and the regulatory bodies from healthcare providers while providing them with limited resources and increasing workload at the point of care delivery; and also expectations from peers and family which affects the behaviour and quality of service by the healthcare providers. These will be discussed in the subsequent section.

*Demotivation and burnout**:***

Branch *et al.* (2017) in a study in the US argue that medical practice today is extremely stressful. Physicians are experiencing a loss of control especially of their practices and in decision-making processes. They frequently feel that they are being bogged down by increasing bureaucratic control of their profession by the government and rising expectations from health professionals by society, government and indeed by their own community. The conflict between altruistic practices and limited time and resources is affecting health professionals at an emotional level. They feel they are being required to do more for a lot less. According to Branch *et al*. this is leading to an increasing incidence of burnout syndrome in health professions: they conclude that a "determination to live by one's values, embedded within a strong professional identity, allowed study participants to alleviate, but not resolve, the barriers" (2017 p.2320).

In this study a clear link was established by the respondents between a lack of support - structural, psychological and physical - and the demotivation in health professionals that develops over time towards behaving professionally. Oleson (2004 p.83) in a US-based study using Maslow's hierarchy of needs model explored "the relationship between basic human

needs and money attitudes in a university-age cohort". In his model Maslow (1943) identifies humans as perpetually needy beings. He argues that human needs are hierarchical and unless the lower levels of needs are met, the individual does not move on to the next higher level of need/s. Oleson (2004) confirmed a relationship between money attitudes and needs and concluded that the greater the needs, the greater the desire and motivation to earn money to fulfill those needs. When those needs are not met, the situation leads to anxiety, stress and over time demotivation and a sense of helplessness and apathy towards job-related activities.

Shahid & Zain (2018) identify professionalism as a complex multidimensional, psychological and behavioural construct that influences how much energy, time and effort individuals invest in a task. Zajda (2015), citing Freud's work, postulates that motivation has been viewed as a primary result of needs, thus basing motivation on intra-individual factors. Similarly, Chretien & Tuck (2015) relate motivation to goals and desires whereas Yamani, Shakour & Yousefi (2016) focus on socio-cognitive perspectives and the influence of social-contextual factors.

In this study, emerging themes related motivation to the availability of basic structures within the healthcare delivery system, in the absence of which healthcare delivery, patient-centeredness and medical professionalism all become irrelevant. This is clear from the following quote by a physician:

> *"We work in a highly volatile and unsafe environment. There is no protection offered to the doctors. Every day a doctor or a nurse gets abused by the patients or their relatives, even to the extent that in a hospital recently a lady doctor was locked in a room by relatives of a patient that expired. Thank God that other doctors were able to help her otherwise anything could have happened. We work in an environment of fear and helplessness…and you expect us to be fully professional in our dealings with patients… that no longer is our primary concern, to stay safe in this dangerous, life-threatening, unprotecting environment is our first concern sir!"(NRBF6)*

Job security and freedom from monetary concerns:

Participants believed that job security leads to general satisfaction, which allows healthcare providers to focus on their job and professional commitments. On the subject, one faculty member in her group discussion remarked as follows:

> *"In army people come from different backgrounds. They work together, work hard but they get no good income but they have sense of security." (FCEF5)*

It was interesting to hear that medical students who were still a few years away from worrying about their employment status were quite vocal about the lack of job security and how that, in their opinion, could affect the doctor-patient relationship:

> *"There is no job security…not anymore, especially in the private hospitals and even in the public ones…this has a negative effect on doctors' attitudes and actions towards patients… they become money minded and are always looking for other jobs rather than concentrating on their work. They are depressed." (MSBF7)*

It appears that healthcare providers in this study are struggling to find a fair, protected environment with appropriate support structures for self and family while succumbing to economic burdens due to inadequate pay and lack of incentives. All the healthcare provider groups including policymakers agreed that public healthcare delivery service was not a lucrative employment. An allied health sciences student on the subject remarked:

> *"Socio-economic status also affects. If we are having better jobs, better opportunities otherwise we are also doing malpractice." (AHCF4)*

Lack of satisfaction was connected to poverty and an inability to lead a quality life in the pay health professionals get:

> *"Because it is the poverty and people want to lead a good life."(MSHF4)*

One of the participants in the faculty members' focus group discussions provided the reason for a change in behaviour in a doctor from a public sector clinic to a private clinic, which in his opinion is incentive based:

> *"A doctor in private clinic will get immediate reward for the task he will perform but in government department, a doctor will get fixed remuneration whether he works or doesn't work and he will not be paid for extra time, so remuneration for his work has made a difference. He will definitely go one hour earlier and will sit late at night and will not leave until patients are coming in his private clinic because he would get good and immediate reward for his clinic time. Our organization system should be reward and punishment oriented. Doctors say there will be no promotion so why should I work here? I think being promoted is [the] right of a person." (FCIM12,)*

Another doctor also remarked on the imbalance between money spent on education especially if it is private medical education and the opportunity to recover that money through employment and an ability to live a quality life in this profession, which in his opinion was likely to affect the behaviour of doctors:

> *"Our students get high marks for getting admission in MBBS and pay high fee for becoming a doctor but after completing their education they are unable to get job. If they get job, there is lack of facilities like, electricity, residence and remuneration to be awarded to doctor. Expenses and cost of living of doctors is more than other professionals. If a doctor wants to get a house on rent and tells the owner that he is a doctor, the owner of house would think that he is doctor and will be charging the patient more and he will charge more from the doctor." (FCGM1)*

While the policymaker group, the people also responsible for making monetary incentives policy, provided an insight into this dilemma:

> *"When doctors go on strike, they say they do it because they are not being paid well. But they can only be paid at par with other government pays at that scale. There is a budget to be followed and there are only limited financial resources, if the government spends all the money earmarked for health on doctor's pay then how will it provide healthcare?" (PMAM1)*

Progression opportunities and career structure:

It seems that in an environment charged with mistrust, with imbalance between resources available and requirements, poor pay and lack of incentives, the participants in the current focus group discussions also complained of lack of educational training opportunities to

strengthen competence and build confidence and when such opportunities are made available, the participants felt that pressures of workload make it difficult for them to avail these:

> *"There are educational and training opportunities, but the workload is so much that we do not get time to benefit from them." (FCJF3)*

Participants in all stakeholder groups representing healthcare providers including students lamented the lack of a career structure and job description at public sector healthcare delivery institutions. They felt that this factor demotivated healthcare providers and the lack of job satisfaction and a feeling of uncertainty related to the job and work most likely contributed to sliding standards of care practiced. On the subject, one faculty member commented thus:

> *"In a private hospital if you work you get promoted on time and become a professor in ten years or so. In the government sector there is a career structure but it is not followed. That which is not followed might well not exist." (FCLM4)*

Similarly, an absence of a proper job description in the opinion of the participants left them uncertain and anxious, not knowing what they would be asked to do next or what really was expected of them:

> *"The reason behind the lack of professional behavior is that there is no proper job description for any job and job description is not being followed and there are no specific standards and tools by which assessment of the job holder can be done." (FCCM2)*

It seems that the absence of a functional job description and career structure possibly leads to early burnout, frequent medical errors and a lack of interest in and commitment to the profession.

Adequate resources:

A lack of sufficient resources to cater for the workload especially in emergency situations and acute medical care scenarios was also identified as a possible challenge to medical professionalism. This is in line with the findings of Gondal, Khan and Ahmed

(2015), who identified lack of resources amongst others as a factor challenging professional behaviour. In another study in Ghana, the authors reported that the foremost demotivating factor for healthcare providers in their study was a lack of resources at the hospital, which also was inadvertently responsible for lack of professionalism (Jack, Canavan, Ofori-Atta, Taylor & Bradley, 2013). Similar concerns were raised by participants in various focus group discussions in this study:

> *"First of all resources. If you have casualties of patients and there is only one ventilator available in ward what will you do? You have only one emergency trolley and wheelchair how will you manage? There are two patients on every bed. Deficiency of the resources and moreover, the expectations of the patients. They are not educated, they do not know what we are doing. They just enter in the room and want to be treated first and at once. In emergency, one doctor is there with only one kit. There are number of casualties she can't do something." (MSAF4)*

Konrad *et al.* (1999) comment that the pace and volume of workload overwhelms healthcare provider and it becomes difficult for them to maintain best behaviours. A further testament to the political nature and structure of the healthcare delivery system in Pakistan, according to the participants, was an unfair and unequal distribution of work across individuals and teams:

> *"Yes it happens they say so. In private already one staff deals one patient because they are on floors but in wards there are 60 patients then how could she manage all the things. One says his drip is stopped other says she went to that patient not to me first. Every type and every class of people are there in wards……and then the junior nurses get the larger share of the workload and the seniors, just because they are seniors, don't share the workload equally….this is not fair." (NRDF5)*

It might appear that an atmosphere of mistrust exists between the healthcare providers and the patients they serve. In such an atmosphere, medical professionalism might find it difficult to flourish. Understanding the plight of the doctors, one patient retorts:

> *"Doctors will definitely be irritated as they have to treat hundreds of patients. Total number of doctors is fewer and should be increased so that workload of each doctor may be distributed. In this city, there are only two hospitals for the*

> *sixty lac population. Small units of hospitals should be established in each area to decrease the workload of patients in the central hospital." (PTAM7)*

In the following comment a medical student highlights the reason he feels doctors fail to serve in rural areas:

> *"Seats are available in rural areas but no doctor is willing to serve in rural areas as there is a lack of facilities in rural areas." (MSBF7)*

This lack of amenities and a lack of the life structure that one takes for granted in an urban setting is somewhat lacking in the rural area. It is a reason which one day might go on to stop him from serving outside the urban centres where the quality of life is perceived to be much better than in the periphery where people need doctors most. One medical student argues that extra incentives should be provided for serving in hard areas:

> *"The government should provide extra incentives to healthcare providers to work in rural areas." (MSBM5)*

Support structures within the society:

Another emerging theme identified by the stakeholders was the requirement for support not just to the health provider but in fact to the health provider's family, ensuring that mental and physical resources that otherwise would be spent on worrying about one's family are spent on patient-centeredness. A happy healthcare provider is a professional healthcare provider. This interesting aspect of support was highlighted in the medical students' and faculty members' groups only. Citing an example from another country a medical student remarked:

> *"I was reading an article, I don't know the name of country, I think it is Canada….in which doctors are given facilities like telephone, residence, free children education and they went to countryside even their children are studying in cities and doctor are able to see their children on weekly basis." (MSEF15)*

It is a concern for the family that takes precedence over concern for the afflicted and ill as one doctor remarked:

> *"I will never go to an underdeveloped district! What will happen to my family?"(FCLM5)*

The participants were concerned that the lack of a general support structure within the community also has an effect on their behaviour and the way they handle their jobs:

> "*The doctor knows he has to finish the clinic, why, because he has to pick his children from school by the school off time, there is nobody who can take care of his problems and he has to .....if he doesn't get rid of the patients there is no way out of this situation for him."(MSEF1)*

Politicisation of the Workplace:

Health institutions to the participants seemed highly political places where merit and transparency appeared to be violated frequently on account of various political reasons. These political reasons according to the participants had a cascading effect leading perhaps to unethical and unprofessional behaviour. One faculty member argued that patients who have reference from influential people in society, use that reference to get selected into positions of influence with disregard to merit, they then feel duty-bound to serve the people who placed them into that position rather than the public:

> *"Because it has been politicized as by reference, ineligible people came to the place. If you will give me vice chancellor seat of medical university I am not eligible and I will try to do something continuously to save my seat. Everywhere is same." (FCEM16)*

'Reference' is a term used in this culture to refer to a request from someone of importance to the healthcare provider to help the patient jump the queue, for example, or gain other benefits. One patient stated:

> *"'Reference' is being practised in our society but should not be practised. Getting benefit and treatment on priority-basis is totally wrong as it makes patients with lack of 'reference' feel inferiority complex and exploits their right of being treated equally." (PTAM)*

The quote provided above signifies that when one healthcare provider is under threat, the entire community of practice feels threatened; the profession is under threat. Under such circumstances, healthcare delivery becomes menial and mechanical and quite superficial.

4.6.1. Summary of SUPPORTED

Altruism, the motivation to put another's needs and interests before one's own, is a virtue often associated with professional behaviour. It is a relatively recent idea: Harris (2017) states that the term 'altruism' was introduced as an opposite to 'egoism' by Auguste Comte in the 19th century. Jauregui, Gatewood, Ilgen, Schaninger & Strote (2016) argue that under the current socioeconomic, cultural and societal frameworks prevalent around the globe and with the rising influence of commercialization on the profession, maintaining altruistic ambitions often leads to burnout among healthcare providers. In my study, factors like lack of job security, job satisfaction or resources and rising political influences appear to be making it difficult for healthcare providers to keep the interest of patients and the public above their own. It seems that healthcare providers feel themselves to be in a 'rat race' for the survival of their professional career and for sustenance:

> *"A doctor not satisfied with his job, the working environment and the poor working conditions can hardly be expected to behave professionally!" (FCKM1)*

SUPPORTED is a theme that stands out as very culture-specific in that it has not been highlighted as a component of professionalism in world literature. Yet it is one theme that was stressed by all the stakeholders. They were united in their belief that an external support structure that safeguards the basic needs of the health professional and an internal support structure that protects the health professional from harm from the society and the system is essential for medical professionalism.

I believe that the theme emerges strongly in this study as a result of the specific socio-economic and health and safety issues health professionals face in this country.

The circumstances that make this theme emerge here might not be present to the same extent elsewhere in the Western world. Or, the various aspects of this theme may perhaps not be considered as elements of professionalism because they appear to be in contradiction to the notion of altruism as being the defining attribute of professionalism in such cultures.

Nevertheless, as has been argued, the healthcare work force is a very precious resource of a society and needs to be protected and supported in order to maximize optimal output – which could be seen as a criterion of professionalism.

4.7 Summary of Chapter 4

This completes the presentation of findings from the FGDs, in comparison with evidence from the world literature. These findings comprise the response to RQ1: *What are the perceptions of doctors, nurses, students, administrators and policymakers in the Punjab, Pakistan, regarding medical professionalism?* And to RQ2: *How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?* The next chapter will extend the discussion of these findings in relation to the third research question: *How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?*

Chapter 5 Findings in Relation to Research Question 3

5.1 Introduction

In the previous chapter I have presented the findings from the focus group discussions as they made sense to me through the iterative thematic analysis data distillation process employed. These findings provide the response to RQ1: *What are the perceptions of doctors, nurses, students, administrators and policymakers in the Punjab, Pakistan, regarding medical professionalism?* Alongside the presentation of these findings, evidence in the available regional and international literature has also been presented and compared (RQ2). These findings support the view that medical professionalism is a complex and multidimensional construct, sensitive to situation and context that is bound by an internal code of ethics and virtue and involves competences and attributes peculiar to medicine itself. This conceptualization of professionalism within the practice of medicine has evolved over multiple millennia. Its true nature is identified in the challenges at the intersection of internal and external morality and how physicians respond to these in the light of increasing workloads, changing social and democratic responsibilities and evolving belief systems of stakeholders across the framework of practice. *The Internal Morality of Medicine* (Miller & Brody, 1995) identifies the practice of medicine as governed by a moral framework and a code of ethics that defines the professional practice within its role-specific, clinical virtue context. This conceptualization of clinical medicine is based on the fact that as a profession, medicine was a long-standing tradition that is constrained by a set of internal ethical goals and responsibilities specific to the practice itself (Callahan, 1996). This lies in contrast to the notion of the external morality of medicine that assumes that the practice is also governed by certain external ethical constraints, virtues and responsibilities that arise out of the context, culture and fundamental rights of patients and peers that guide the practice (Veatch, 2001).

This debate of internal/external locus ethics within practice of medicine helps guide ethicists and professionals in identifying whether a challenge to professionalism leis within or outside the constraints of the practice itself (Veatch, 2000).

Next, in response to RQ3, similarities and differences emerging from various stakeholder groups will be compared and discussed.

5.2. Differences and similarities amongst the various stakeholder groups

In order to answer the third research question, that is: *How do the perceptions and understanding of "medical professionalism" differ amongst various stakeholders within the healthcare delivery system in Pakistan?,* a number of strategies could be employed individually and in combination. A quantitative analysis of how many times a certain 'code' was identified in the focus group discussions of various groups and then comparing the different groups could have been one of these strategies. However, such a quantitative analysis would easily have mislead the reader simply because a difference existed between the number of focus group discussions for each stakeholder group and the number of participants within each discussion group. Thus, it was only possible to project rough estimates of the most commonly occurring codes and themes within each group.

However, as the data was read and re-read multiple times, it became clear that 'codes' and 'themes' that were identical in various group discussions had different underlying connotations. An appreciation of the varying interpretations of an otherwise similar theme resulted in building an understanding of the phenomenon that was unique for each stakeholder group. This resulted in themes that emerged out of individual stakeholder groups' discussions that are further explained later on in the section.

Each group, not surprisingly, was found to have their own separate view of the 'life world' within which this phenomenon was embedded. Thus, for example, the patient

stakeholder group viewed ‘medical professionalism’ from their perspective of patient care and everything related to this within the phenomenon as it exists in the ‘life world’.

5.2.1 Faculty (Basic & Clinical Sciences Teachers and Doctors)

> *“I believe that a doctor who is able to manage the workload with competency of skills while maintaining good behavior and attitudes is a good professional.”*

One of the greatest challenges to professionalism in the opinion of this group is the excessive workload in the healthcare delivery environment leading to unprofessional behaviour and lapses in patient care. While other groups also recognized and mentioned as a challenge the excessive demands placed by the system on health professionals, this issue was most emphatically raised by the faculty group. The group believes that healthcare providers need to develop skills and attitudes that allow them to function within these excessively stressful healthcare environments. These include good managerial skills and managing physical and mental stress, which they consider part of professionalism.

Linked to this recognition of the demands of the job, this group more than others argues for a healthcare delivery structure that supports the practitioner and his or her interests just as much as it does that of the patient. They argue that doctors and other healthcare providers are expensive and rare commodities and should be treated as such. They believe that health professionals should be provided with a safe working environment with appropriate resources, incentives and pay. They believe that these measures promote professionalism and to strive for these is as much a component of professionalism as striving to maintain ethical standards in practice.

> *“Every health professional has a duty to encourage and strive for the development of a proper job structure, career pathway and pay package within the industry for the community. This is part of professionalism.”*

This group was most concerned about the challenges in career progression and its role in developing professionalism. They argued that career progression in Pakistan in many cases requires political enslavement and breaking away from the norms of this highly political environment frequently results in being left behind in the rat race to the top. They argued that political favours are quintessentially unprofessional and the ability not to succumb to these political traps in order to gain promotions or benefits is an essential part of professionalism. One doctor remarked:

> *"We are always under political pressure to do this or do that. Just as an example, we cannot even run our outpatient department fairly. Every time I go to the outpatient clinic in my public sector hospital, I am asked to see political referrals first and have to make poor patients who do not have any political leverage or influence wait till I am finished with these queue-jumpers."*

Nevertheless this group also extensively debated the importance of ensuring patient satisfaction and even preserving those rights of the patients that the patient might not be aware of but which the profession demands that they be maintained:

> *"Rights of the patient take precedence over everything else."*

However, this group recognised as an issue that a belief system exists in the society that is based on cultural and religious values and precedence that challenge sound professional behaviour and practices by doctors. They argue that it is part and parcel of professionalism to delicately but firmly challenge such belief systems in the interest of the patient and public safety at large:

> *"It is common practice to put cow dung over the severed umbilical cord at the time of birth in villages. How can you be part of this practice, even though your patient and their relative demand this of you? It will be unprofessional to let them do this."*

Keeping up to date with developing knowledge & skills:

> *"To practice evidence-based medicine and to actively seek out and learn newer techniques and knowledge related to the profession is professionalism."*

Along with MBBS students and policy makers, the faculty groups emphasised continuing professional and personal development as a means to advance professionalism. This group believes that a practice based on outdated knowledge and skills is fraught with danger for the patient and the practitioner. They argue that it is the responsibility of every practitioner to continue to update the knowledge and skills set in order to provide the best care to his or her patients.

Transfer of skills and knowledge to the next generation:

Almost entirely within this stakeholder group, the discussion frequently shifted towards professionalism in light of the ability to teach and train effectively the skills and knowledge and the art of medicine to the next generation of medical professionals. This group identified this as an important aspect of professionalism, to an extent where one participant argued that this 'is the soul of medical professionalism'.

5.2.2. MBBS Students

Medical students seemed to be particularly conscious of the challenge of ethical dilemmas, perhaps because they are already sensitised to discrepancies between what they have been taught and what they see being practiced by those who are expected to be their role models, this group also points frequently in their discussions to the need for maintaining sound moral and ethical values under challenging circumstances within the healthcare delivery working environment:

> *"Professionalism is all about sound moral values and adherence to ethical principles under all circumstances."*

This is the only group that identified the importance of the need to be taught about the reasons for practices. They believe that it is this 'why' that is missing in their teaching and training in the undergraduate curriculum, and when it is taught it gets muddled up by certain

challenges in the hidden curriculum and the environment. They believe that to be able to seek out the 'why' and to understand the reasons behind it is an important component of professionalism:

> *"We are taught to do the right thing at the right time but there are many aspects of patient management where we are not taught as to why we have to do this. Like for example, in taking history we are taught to take socio-economic history and are told that it is because it affects treatment planning, but when it comes time to plan treatment we hardly ever consider that. You know… I mean… like we don't know why?"*

They too noted the challenges that cultural and societal values place on professionalism. They were particularly concerned with the differences in cultural norms as compared to the best practices taught in the curriculum. Moreover, they voiced their concern over the same role models that were involved in teaching their medical students these best practices in classrooms but deviating from them in their own practice. This mismatch between the taught curriculum and the hidden curriculum came up frequently in discussions in focus groups. They argued that sound professional behaviour is frequently threatened by the cultural and societal norms like accepting gifts, asking for and valuing referrals from influential people for jumping queues, not taking consent from the patient but rather from the son of the patient, hiding disease facts from the patient, and so on. They argued that to rise above these cultural and societal challenges and to do the right thing professionally is an attribute that defines professionalism.

> *"Sometimes, a patient's son would come to me and say that please do not tell my mother the disease she has, just do the amputation or whatever without informing her, she is a frail old lady, she cannot be expected to comprehend what you will tell her. I tell them that this is against professionalism."*

The MBBS students concern themselves over the hidden curriculum and the role models within it. This group more than any other group identifies that the environment and the role models lead them to believe and do things that are not professional. They discussed

how this environment challenges their teaching related to professionalism. They believed that in the presence of forces that pull them away from sound professional behaviour, it is also an important aspect of professionalism to resist these forces and continue along the right path:

> *"We are taught to take consent from patients and that it should be a voluntarily given completely informed consent. But in the wards we see our seniors asking patients to sign the consent document without explaining anything to the patients and when we fearfully ask them why they get angry at us and say that, if they explain everything to the patient, he won't likely understand much, would waste their time or become afraid of the procedure and run away. There is so much difference between what we are taught and what we learn from the wards."*

The MBBS students are well aware that the medical profession is portrayed as a means of earning huge amounts of money at the cost of ethical and professional practice. This is what they argued over in their group discussions more than any other group in this study. (On the other hand the patients were quite perturbed at this rising commercialization within the medical profession, as can be seen below.) In the discussions the medical students said that they see their seniors skipping duties and neglecting patients as a norm to run after the monetary gains of the private patient. They referred to the projection of the patient in the industry as a means to a good quality of life through charging huge amounts of money and by ordering unnecessary tests and referrals. This they argued is a challenge and one that affects professionalism. They said that to be a medical professional requires one to serve humanity without cost labels attached. One participant stated:

> *"Patients are not tasks one takes over against money. We as a medical professional have taken an oath to serve humanity and we should not be so money-minded that we forget the oath that we take and start extorting patients for money."*

Treating patients as fellow human beings:

The MBBS students' group was the only one that talked about the fact that teaching and training in their undergraduate education is about everything related to medicine except how

to handle and manage patients at a non-technical and non-scientific level: that is, at a human level. They argued that they have to struggle to keep the patient at the heart of all learning and training and not get emotionally desensitized and detached. This in their opinion is part of their professionalism arsenal.

> *"Pithing frogs in physiology labs and dissecting dead bodies in anatomy lab makes you feel numb. It is difficult to think of a patient as more than that frog or that dead body one dissected for two years. But then professionalism demands that one does not lose the ability to empathize and even of sympathy and care."*

Appreciating the role of teamwork, leadership and management:

> *"Team-work, management skills and leadership skills are necessary for professionalism."*

MBBS students emphasised the importance of learning and practising good managerial and leadership skills. They believed that to possess these skills and to practice them, especially in a team setting, is an important component of professionalism. However, they were concerned that these traits were not included as part of the taught curriculum. They had to acquire these skills through observing the practice of their role models. This, they believed, was challenging as they needed guidance to develop and practice these skills.

5.2.3. Allied Health Sciences Students

The struggle to establish their identity as effective and productive members of the healthcare provider team is a key concern of the allied health sciences participants. They feel their work is trivialized in comparison to that of the doctors in the healthcare industry and they share these feelings with the nurse group. They frequently stressed that to able to understand one's place and role within the healthcare delivery system and to maintain functionality to that extent regardless of the opinion and perceptions of others is a key element of allied health sciences professionals' professionalism. One student remarked:

> *"We are treated as clerks by the doctors and nurses and patients also do not appreciate what our role is in the team. To exhibit professional values it is necessary that we believe in ourselves, believe that we have something different to offer to the patient, which is different from what the nurses and doctors do. We are not their sidekicks, but we are health professionals in our own right."*

One of the greatest concerns that was highlighted by this group alone was regarding the ability to regulate practice in a system where no official governmental or non-governmental body exists that oversees the functions and practice of allied health sciences in Pakistan. In the absence of such regulation, the temptation to waver from the right path in their opinion could lead a health professional astray. Being able to rise above this temptation and self-regulate practice as well as being prepared to regulate the practice of peers, they argue, is a part of professionalism.

> *"We have to protect and safeguard our profession and professional values. If we have to blow a whistle on someone doing something unethical so be it… we have to gather the courage to do the thing right and make sure others are following the same standards. This too is professionalism."*

As they are embarking on a professional journey which is not supervised by any regulatory body in Pakistan, which is not fully accepted in Pakistan and one which in many ways is stigmatized, the allied health sciences students believe that self-sacrifice lies at the heart of their professionalism. This was a recurring theme in all stakeholder groups but increasingly so in the discussions of the allied health sciences and the nurse groups. To develop a sense of sacrifice for the promotion of their speciality and in the interest of the public and patients is paramount in their opinion to being a good allied health sciences professional:

> *"A good professional will be willing to sacrifice a lot in the interest of his profession. The honor of the profession comes first. He will not let the profession down at any cost."*

Allied health sciences students group believe that they work in a society where cultural prejudices and taboos direct the treatment desires of patients. They argue that a large majority of the population, especially in the rural areas, still prefers traditional treatment to so-called health professionals that are not registered by any regulatory authority. In their opinion, a sound professional should be capable of guiding the patient to accept the right treatment by the right personnel. One participant remarked:

> *"Patients still want to go to traditional bone setters rather than come to us for physiotherapy. They think we are incompetent masseurs. Professionalism demands that we inform patient and the public of our role and the dangers of going to quacks."*

Morality education and maintaining sound moral values is therefore an important aspect of professionalism for this group, one that takes precedence over practice for monetary gains. In their discussions they highlighted the importance of morality and ethics quite frequently, as did other groups. Like the MBBS students they still have to face the ethical challenges of real work. But on top of that, they are struggling with an identity problem, a feeling of stigmatization and – importantly – much less in the way of financial reward which might make all this worthwhile. They maintain that maintaining the moral compass pointing in the right direction is not an easy task in an age where quality of life is expensive to maintain, but they argue that morality and ethics are the foundation of professionalism:

> *"A morally straight professional is the only professional."*

Good management and teamwork:

This group too stressed the need for exhibiting good managerial skills at work and beyond. They believe that a good manager is a sound professional capable of getting things done efficiently. As a minority group with perhaps lesser recognition in public, good management, effective leadership and communication were to this group more important and stressed far

more than any other group. They maintained that since healthcare provision is a team effort, being able to manage one's tasks allows for the entire team to be successful in its efforts:

> *".....managing one's practice is very important aspect of professionalism. I am not talking about resources, whether they are the best available or limited…. I am just saying that the professional has to be a good manager at work and then he will be able to contribute well to the healthcare team"*

5.2.4. Nurses

This stakeholder group, together with the allied health sciences group, were the most vocal on their perceived status within the society. Nurses, more than any other stakeholder group, feel that their identity as a healthcare professional is under constant threat from doctors, patients and the public. They maintain that their work is trivialized and they are not taken seriously. They find that the environment that they work in is sexist at times and dangerous at others. Under the circumstances, maintaining an identity that is rooted in their professional self and allows them to function regardless of the opinion around them, helps in the professional discharge of their duties. This key aspect of professionalism is a part and parcel of the identity of a nurse they reiterated time and again in the discussions.

> *"Professionalism I believe requires one to believe in herself and her ability to do good for the patients and the society."*

Nurses, even more than the allied health sciences group, frequently commented on the various social and religious restrictions they felt challenged them, their work and their identity. In a male-dominated, conservatively religious society, nurses felt that they were not taken seriously and their role as an important member of the healthcare team was being marginalised. They felt that as professionals, being aware of these challenges, they need to overcome them through sheer mental effort and not let the challenges be projected in their actions. One of the nurses on the topic commented:

> *"Society and even doctors do not give us much importance because we are women mostly and some of us are non-Muslims, but we have to forget all this, believe in ourselves and carry on doing good and working better and better each day. We should know what we are and what our role is in the healthcare delivery system and we should politely but firmly assert it."*

The conflict between monetary benefits and patient care was a recurring theme in all the groups. However, nurses provided a unique perspective by virtue of being a member of the healthcare team which cannot like doctors or allied health professionals establish private clinics and provide services for private consultation. In their opinion, selfless service to humanity is the essence of professionalism. This, they believed, requires putting the interests of the patients above their own and that of their family. These interests, they maintained, included financial and monetary incentives including but not limited to 'gifts', for example as bribes to see a patient first. One nurse remarked:

> *"There are so many patients on the ward and just three or four nurses. Everyone wants attention first, but we know who needs it before others, so like we have our priority list of jobs to be done. Patients' attendants come and offer money to see their patient first, but it will be unprofessional to do so."*

Every stakeholder group stressed the importance of the health professional as a role model. The health professional has the means to bring about a positive change in the society: this is an important aspect of professionalism. Nurses believed that to be a professional requires one to project the best moral and ethical principles with the realization that she is being watched and copied by not just colleagues but because, being in a position of influence in the society, the heath professional also acts as a role model for everyone in the society. As a socially stigmatized and economically marginalized group, nurses were very vocal on good role modeling, portrayal of best attitudes, and observance of excellent behaviours and leading through example. They believed that their professionalism demanded maintaining the highest of standard of care even at the expense self-sacrifice:

> *"I try to be polite, caring, affectionate, attentive and efficient in my duty and in my interaction with my peers and colleagues. I believe that I am a role model for others, not just my juniors and colleagues but the rest of the society. They look up at me and they will try to be a little like me. I feel that professionalism requires you to uplift the behaviour and attitude of the entire society by adopting this role."*

Good managerial skills and team-work:

Nurses in their discussions frequently referred to their role as a manager and as a leader in various activities involving patient care. The notion of a healthcare provider that is an equally good manager of tasks and resources, can form teams and work within them, and lead teams to accomplish tasks, is more central to the idea of professionalism in this group than in any other group. One nurse commented:

> *"Being a nurse is all about being a good manager and to have leadership skills as well. We are taught it in our schools as well and when we start work we realize that half of what it is to be a nurse is being an effective manager."*

All stakeholder groups highlighted lack of resources as something that leads to unprofessional behaviour and risks patient injury or neglect. Nurses in their discussion stressed that professionalism demands having an ability to utilize the resources available most efficiently, providing enough care to treat the problem while maintaining best professional behaviour and attitude. This, they believe, is something a health professional learns as part of the workplace environment through experience, but they stress the need to include training in this area as part of the taught curriculum:

> *"Pakistan is a developing country and resources are limited. I have worked in Saudi Arabia as well and even there, with so much money, they cannot manage complete free care for all. Lack of resources in the face of patient burden and workload leads to frustration amongst healthcare providers, which in turn leads to unprofessional behavior. A good professional knows how to manage his workload and a great professional is one that is able to work within her resources to provide the right amount of patient care without failing in his duties as a professional."*

5.2.5 Policymakers

> *"Medical professionalism demands keeping the interests of the patient foremost at all stages of her care."*

The policymaker group highlighted the importance of keeping the patient at the heart of all activities in a healthcare delivery system. They believed that medical professionalism fails when the patient is not the sole reason of the service. This covers, in their opinion, every aspect of professionalism and forms the central pillar of their view of the phenomenon.

Nevertheless, the policymaker group more frequently than any other group in their discussions came up with the notion of economy of service. This economy of service included monetary, physical and mental economy in the discharge of duties by the health care providers while ensuring optimum healthcare. They believe that it is impossible to provide ideal healthcare to the entire population. In the presence of this dilemma they argue that it is only efficient that the best care that can be provided using as little physical, mental and monetary resources should be made available, so as to extend the reach and limit of that care. They link this directly with medical professionalism.

> *"A medical professional needs to be efficient in the discharge of his duties, utilizing minimum resources of time, infrastructure, money, human capital and mental strength in treating one patient enough to get the job done and then moving on to the next."*

Alongside this emphasis on the most efficient use of resources, the point that the right person in the right job promotes professionalism was stressed only by the policymaker group. In their discussions, the group members repeatedly stressed the importance of right, meritorious selection and future monitoring, basing the selection and monitoring criteria on sound professionalism principles. They believe that this will most certainly improve medical professionalism. One of the members stated it thus:

> *"Medical profession is a difficult profession. This is because medicine is thought of as science but the practice of science brings healthcare providers in contact with other humans, namely patients and fellow professionals. It is therefore paramount that an environment is created that promotes the art of interaction for the science to flourish. This can only happen if we teach the art and make sure we select the right person for jobs that they are competent to do in terms of both the science, the technical bit and the art, that is the human bit."*

Training in leadership, team-work and good communication:

The policymaker group more than any other group emphasised the need for training in leadership and managerial skills and related medical professionalism as well as a successful healthcare delivery system to team-work, effective management and leadership. They emphasized that being a health professional requires one to be a competent and effective manager of tasks and a leader as well as a team member at the same time. One participant remarked:

> *"One of the fundamental ills of the profession stem from the fact that we teach science and train them in doctor related skills, but we never train them in how to manage their life, their profession, cope with physical and emotional stress, respect and value teamwork and to lead by example. These are as much a part of being a health professional as having the knowledge and skill to give an injection of drug."*

Training in ethics and cultural awareness:

Apart from education in managerial and leadership skills, morality and ethics education, according to the policymaker group, was an area that was left unattended throughout the training at both undergraduate as well as postgraduate levels in health professions education, leading to possible unethical and immoral behaviours in the professional career. This group repeatedly stressed that morality and ethics education should be part of the taught curriculum and reflected in the hidden curriculum. They went as far as advising that inductions and promotions should reflect morality and ethics competence:

> *"It is important that only those with the highest moral character and best ethical values be selected right from admissions into undergraduate education to passing*

out, and then induction in to the health civil service and promotions within it. This is the only way to promote professionalism in my opinion. This also ensures that the right role models will be available to the service."

The policymakers also stressed the understanding of the cultural belief system that exists in the society and being cognisant of this when interacting with the patients in order to gain their trust while at the same time being professionally correct in their dealings. They stressed that a patient-centred approach towards healthcare requires health care professionals to respect the belief system of the patients and to challenge it with evidence only if required and that too with the interest of the patient and public in mind:

"We deal with a patient population that is largely illiterate and still believes in age-old traditional methods of cure. It is important that we should not be too aggressive in challenging these beliefs, but rather convince the patient to our newer, safer techniques. Otherwise the patient is just going to leave and go to a quack."

5.2.6 Patients

Communication in relation to professionalism was brought up more frequently by this stakeholder group than any other group. Good and effective communication was found to be central to the conceptualization of 'medical professionalism' by the patient group. The group frequently related lack of or incomplete or improper communication between themselves and the healthcare providers as a leading cause of lack of professional behaviour leading on to patient dissatisfaction and injury. The group placed great emphasis on communication skills teaching of health professionals and on continued monitoring of proper communication skills being exhibited at various levels of patient-health professional encounters:

"Professionalism and good communication are synonyms. A doctor or nurse should be able to patiently and clearly communicate with their clients and amongst themselves as well. A polite word here, a kind gesture there, an attentive look, a caring nod, all these and many more help the patient to relax and establishes rapport between the patient and the healthcare provider and most of

> *all the patient starts to trust, not just in the healthcare provider or the health delivery system but starts to trust that he can actually get better."*

Related to their concern for good communication skills, the patients more than any other stakeholder group felt that 'empathy' was a key aspect of healthcare professionalism. They were of the opinion that unprofessional behaviour stems from a lack of empathy exhibited by the healthcare providers. They believed that this lack of empathy is embedded within a healthcare structure. They believe that there is a lack of training in this area and the increasing workload demands placed on the system are inherently not conducive for the professionals to exhibit this trait. Nevertheless, they believe that being empathetic goes a long way towards being fully professional in this industry. One of the patients points out how a lack of empathy leads to deteriorating professionalism standards:

> *"If only health professionals could place themselves in our shoes, they will understand how difficult it is sometimes to comply with their expectations. They call us to the clinic again and again, not realizing what it costs us, in terms of time and money. I believe that they treat us as if we are inanimate objects, devoid of all feelings and ability to think."*

A concern over societal and cultural norms being threatened and at times disregarded by the healthcare providers came up more often in this group than in any other:

> *"There are certain norms of society, I respect them, so should doctors. They behave as if they are from some foreign land. If they are more educated or richer than us, which does not mean that they should forget their place in the society. I am not saying that they should not challenge the norms of the society, but they should not do so with such an attitude that makes us feel primitive and lacking."*

Society and culture are important aspects of the lived world of not just the patients but all the stakeholder groups. The patients, however, felt more strongly than others that a behaviour that was in line with the expectations of the prevailing culture of the society and its norms was more professional.

This was brought up most frequently in discussions related to consent and the relationship of the right of patients to confidentiality as compared to the right of the entire

family. The concept of guardianship especially of the elderly and the 'feeble' women by husbands and sons and the need to suppress transfer of knowledge of illness to the patient with the view towards keeping them 'safe' from this knowledge was frequently brought up in this group while frequently condemned in other groups.

The ethical and God-fearing professional:

The patient group recognized that a lack of incentives was an important determinant of unprofessionalism in the public healthcare sector at least. The public-private divide in patient care and access to doctor and services was connected to the lack of monetary incentives that are available to the healthcare providers in the public sector. At the same time the patients were of the opinion that even with this lack of incentives, the healthcare providers ought to work true to the oath they have taken and fulfill their duties as indicated in the job descriptions they willingly accepted.

> *"The same doctor because he will receive check-up fee straight in his pocket in a private clinic, speaks better, listens carefully and gives proper time to us, whereas when you see him in a public sector hospital, this same doctor will not listen to a word you say. In fact you don't get to see any professor level doctor in a public hospital even though they take their pay from these hospitals but you have to go to their private clinics at night to see them and pay them hefty check-up fee!"*

Patients more than any other stakeholder group members believed that a healthcare provider who had the fear of God in him would be better and more professional because this fear helped in keeping his morality and ethics straight and in helping him keep the interest of the patient above his own interest. Interestingly, this conceptualization of a medical professional did not have any significant religious connotations but rather, it was considered only as a measure of the professional's ability to do the right thing in the right way knowing that he is accountability to a higher being and is being judged by that being for all his actions.

Patients took comfort in the knowledge that a doctor with that kind of belief will do them no harm. One such patient remarked:

> *"A god-fearing doctor is a good doctor. We feel safe in his care knowing that he fears retribution of God if he harms us."*

Good, efficient management:

Like other stakeholder groups, patients too laid great emphasis on managerial attributes related to professionalism, believing that the presence of such attributes will lead to an efficient and cost-effective (for them) healthcare service. Numerous accounts were provided where lack of good managerial structure and function was linked with unprofessional behaviour and attitudes. One such account is reproduced below:

> *"Health professionals should be trained to manage their work and patients in the medical schools and on the job as well. It is unprofessional to call us for appointments in the Outpatients at 9 a.m. and routinely they turn up at 11 a.m. At other times, they will just leave patients waiting and then a nurse would come and say that the doctor had to leave and now you have to come next week. Would you call this professional behaviour?"*

5.2.7 Summary of similarities and differences between the stakeholder groups

The six stakeholder groups, the policy makers, the medical students, nurses, allied health sciences students, doctors and patients, highlighted similar conceptualizations of medical professionalism as a phenomenon. They maintained that certain skills, knowledge, attitudes and credentials were necessary for medical professionalism. Nevertheless, there were differences in how they perceived professionalism to play out within the societal and cultural context that were dependent on their role within this phenomenon and their unique relationship to the rest of the stakeholders, as well as their place in society and their background.

So, while MBBS students were concerned about a number of essential skills like communication, management and leadership not being taught, doctors were more concerned about how the system could best support them professionally and personally to promote professionalism in the wake of increasing workload. The policymakers realized that neither the hidden nor the formal curriculum was transferring the skills and attitudes necessary to establish professionalism and at the same time the clinical practice promoted everything but professionalism. The policymaker group was concerned with how best to maximize output with limited resources so as to make healthcare economically manageable in the face of rising demands and ever dwindling resources. Patients in particular were more concerned with empathy and communication in an environment that made the doctors and policymakers believe that, because of the workload, efficient management and turnover of patients took precedence over establishing rapport with patients and communicating effectively.

There were groups like the nurses and allied health sciences students that felt marginalized and had identity issues. For them professionalism held a much more sacred meaning, more so than for other groups. This may be because groups that are threatened socially and economically tend to pursue higher standards of professionalism in order to gain acceptability and to establish an identity on a par with similar professional groups like for example doctors.

Yet from their own unique vantage points all stressed what they believed to be an idealised conceptualization of medical professionalism that was bounded by cultural and societal norms, workload and regulatory influences. The majority of the stakeholder groups yearned for resources in order to promote professionalism, The fact that medical professionalism is very contextual, something whose understanding changes from one context, time, situation, culture and environment to another, came out as a recurring theme. Every individual in every stakeholder group viewed professionalism through his or her own

lens of wants, needs, and expectations. Whether a particular behaviour was professional or not depended on the outcome of that behaviour in light of those expectations, needs and requirements by the individuals involved.

5.3. Summary of study findings

This chapter provided discussion on the findings from the analysis of 38 focus group discussions that included 530 participants across the entire complement of stakeholder groups. Participants were of varying genders, ages and demographic backgrounds. The description of the findings and discussions identified the perceptions and sense-making of the phenomenon of 'medical professionalism' by nurses, medical and allied health science students, physicians, policy makers and importantly the patients which was compared between the stakeholder groups and with evidence from literature available in other parts of the world.

The province of Punjab, where all respondents in this study worked and lived, is a diverse region within the equally diverse country of Pakistan. The research study allowed me to make sense of how stakeholders (nurses, doctors, health policymakers, students, allied health sciences professionals and importantly patients) themselves make sense of the lived experiences of encounters with health professionals through the lens of medical professionalism. The participants opened up their life-world for me to peer into, which is presented in this thesis.

To me, it appears that medical professionalism was a very vague and intangible concept for the majority of the participants. Pakistanis relate it to cultural best practices, societal norms and religious values; they confuse it with cultural taboos and myths; they are at times at a loss to differentiate amongst qualified doctors, alternative medicine practitioners, faith healers and quacks. The educational level, related somewhat to their adherence to

cultural and faith beliefs, varies widely across the province. Still, amidst all this fog and sometimes deliberately placed smokescreens, while trying to avoid culturally sensitive questions that trespassed on issues like that of power differentials amongst the practitioners, the policy makers and the patients, a pattern emerges that is quintessentially Pakistan's understanding of medical professionalism.

This pattern describes a professionalism in which the practitioners and their clients both appreciate that the health professional assumes a certain vague but essential authority over the patient. The practitioner is always right, so to say. This is the foundation of the relationship between the practitioner and the patient that defines professionalism in this region. With this superiority based on the professional knowledge and skills the practitioners possess, the professionals are allowed to practise with unprecedented financial and value-system autonomy. They are free to charge at will, refuse treatment if desired, change procedures and protocols at whim without informing people and breach confidentiality, all on account of the demi-god status the society assigns them and which the practitioners accept as their right. In such an atmosphere, medical professionalism and all its attributes are what a particular doctor/ practitioner makes of them in any given situation, setting and context. The patient and society may for a moment consider some act or treatment inappropriate but by and large they accept it as a norm, a right of the practitioner to practise in whichever manner he feels appropriate.

This is not to say that an understanding does not exist of the best values and protocols, requirements and attributes regarding medical professionalism. I found that every stakeholder group, the more literate the better, spoke of the ideal. They talk of virtues and attributes, pre-qualifications and requirements that define medical professionalism in the world literature; they idealize the western conceptualization of medical professionalism but cling to traditions that give unprecedented rights to the practitioners at the expense of the patient. They talk of

change, explain how it can be brought about, talk about areas where change has actually happened, and at the same time are willing to accept whatever the system throws at them. Yes, the resource-constrained, work-overloaded system, coupled with the poor educational and socio-economic status of the large majority of patients, poses unique challenges to the implementation of change for the better, but at the same time there seems to be little desire to change towards what they describe to be their ideal.

I leave this chapter with the following quote, which though simplistic, speaks volumes on the subject:

"Professionalism is a way of practice in a specific culture." (FCCM1)

Chapter 6 Discussion

6.1. Introduction

> *"Normally in Pakistan we try to implement the researches that have been done in western and in all over the world, but our culture and our society is totally different from them. What is the demand of our society may not be demanded in their society. They are more educated and more qualified than our people. It does not mean that we are degrading our society but it is a reality." (NRFM6)*

In this section I seek to compare the findings, that is, the understanding of the phenomenon of professionalism, in the Punjab, Pakistan, with how it is understood in other regions of the world. The detail of how various themes compare with findings of other regional and international studies has already been provided in the previous chapter, alongside the findings of this study. In this section only a general comparison shall be provided. The discussion in this section will be very broad, making links between dominant conceptions of professionalism within a culture and the nature of healthcare delivery in that culture.

Issues to be discussed include the commercialisation of healthcare (linked to the extent of public funding for it) and its degree of regulation; patient-centredness versus a paternalistic model of doctor-patient relations; the role of religion within the society; and the availability and nature of training in professionalism.

6.2 Discussion

A recurrent issue throughout this study has been the complex links between the commercialization of medicine, its regulation and the concept of accountability. Marmor & Gordon (2014) write that before the introduction of Medicare in the US in 1965, US medicine and its professionals enjoyed complete autonomy and self-regulation in almost every area of the profession. It was the community of practice of American physicians, they add, that

regulated medical education, specialist certification and the enforcement of professional norms on the members of their community of practice. They continue,

> "Who could be a doctor, what education and training would be required, and what collegial oversight was operative was first a professional matter and only secondly implicated the state through malpractice or major corporations via the employment of physicians. Medicine was a profession that enjoyed the classic benefits of self-regulation" (2014 p. 412).

This utopian world would come under increasing pressure from scepticism about professionalism and by commercial practices rationalized by market-driven forces (Marmor & Gordon, 2014).

These trends, and the enactment of Medicare in 1965, have over time lead to the establishment of a business model that regulates the profession and professionalism in the US. Brint (1996) claimed that professionalism in the US culture had been reduced. He argued that this reduction has partly been driven from an ethical consideration to a mere job description. This has partly been driven by a revival of the US faith in the superiority of markets since the 1970s that challenged the right of the elite to decide for others what should be produced and how it should be distributed and allocated - the elite in this case being the American physicians whose superiority over the public they served came to be challenged thus Marmor & Gordon claim that the relationship between the patient and his doctor has become commercialized and increasingly referred to as the provider-consumer relationship in keeping with market traditions: "The stereotype of the medical professional as a self-interested (selfish) agent of commerce feeds on itself" (2014. p. 417).

Nevertheless, based on the findings of Project Professionalism in the 90s, the American Board of Internal Medicine (ABIM) identified altruism, accountability, excellence, duty, service, honor, integrity, and respect for others as fundamental constructs of medical

professionalism (O'Sullivan, van Mook, Fewtrell & Wass, 2012). Similar constructs have been identified by other US bodies that regulate undergraduate and postgraduate medical education (such as the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education and the National Board of Medical Examiners).

In addition to those identified above, advocacy, humanistic qualities and ethical and moral standards have also been mentioned (ABIM, 2002; Blank, Kimball, McDonald & Merino, 2003; Swing, 2007). Starr (2008) described the distinguishing attributes of modern medical professionalism in the US as: (1) the possession of distinctive technical competence based on scientific knowledge and experience; (2) a commitment to collective self-regulation; and (3) subscription to a moral and ethical code that elevates the interests of the patient above the interests of the physician.

Currently, the minimum qualifications required to practise in the US are regulated strictly through licensure and revalidation by various specialist boards and state and federal licensing authorities. Marmor (2007) claimed that it was the regulatory control by external bodies as well as by collegial oversight that continues to safeguard the values of professionalism in medicine in the United States.

In our study considerable discourse related to the theme ‘SUPPORTED” was identified. It is not that hints related to this theme are not available in the world literature on the subject of factors which support healthcare workers (or not): however, they tend not to have been grouped together and highlighted, an important difference with this study. As stated in earlier sections this difference can perhaps be related to the fact that the large majority of studies arise out of developed countries with regulations that already extend support and facilitation. Perhaps this therefore does not seem to be such an important

component bearing on professionalism. In Pakistan governments have other priorities than regulating the professions, which are thus left very much to regulate themselves.

In the current study, various stakeholder groups identified themes that relate to the business model of medical professionalism. The main variance with American perspectives reported in the literature can be attributed to the difference in the environment in which medicine is practiced in the two regions. Healthcare in the US can be characterized as commercially driven, regulated by market pressures but also by federal and regional accrediting bodies. Pakistan is also regulated by an overall accrediting body backed by the government: however, the healthcare system still allows a great deal of financial and practice control flexibility to the physicians through the availability and acceptance of private healthcare. Nevertheless, unlike the US, Pakistan also aspires to provide healthcare for all through its public provision.

One of the policymakers in the current study highlighting this difference remarked:

> *"In Pakistan, doctors enjoy a great deal of autonomy in terms of work, professional behavior and fee structure at clinics and consortia they develop. It is this autonomy that has resulted in the public and private healthcare being at opposite ends of a spectrum of care, professionalism and affordability. But at least all citizens have access to healthcare like in the UK, not like the USA where insurance determines the quantity and quality of healthcare one will receive."(PMBM3)*

A study by Roff, Druce, Livingston, Robert & Stephenson (2015) comparing UK, Egyptian, Saudi Arabian, and Pakistani medical students and staff found differences which they believe are a reflection of the higher level of accountability of UK health professionals, both students and staff, as compared to other nationalities in the study, where the health professionals enjoy a greater degree of autonomy with less accountability and responsibility.

This greater autonomy and relative lack of accountability is evident in a quote from a student in the current study as well:

> *"It seems that doctors can get away with murder….they are hardly made accountability for their misconduct and non-professional behaviour, instead the health professionals believe that it is their right as superior beings to treat patients poorly. This is not how health professionals are allowed to behave in the West where they are held accountability for their actions by the public, the media and the government."(MSFF3)*

Canada even with its close proximity to the United States has followed a completely different trajectory on professionalism. Marmor & Gordon (2014) claim that in Canada, commentary on and the nature of professionalism has remained unaffected by the academic and pressure group critiques that defined professionalism in USA. This is largely attributed to the fact that, as in certain other countries including the UK, the state took over the financing of both the hospital and physician services while the academic and professional competence regulation was left to the community of practice. This in Canada has allowed a greater degree of professional autonomy to Canadian physicians as compared to their US counterparts (Marmor & Freeman, 2009).

The Canadian model of healthcare is quite similar to the UK model of the National Health Service and, as such, frees professionals from the influence of market-driven values that could affect professionalism and define patient-physician relationships. Woodruff, Angelos & Valaitis (2008) argued that, freed from market-driven values that could offset the ethical and humane values of medical professionalism, professionalism could be shaped around the teachings of ethics and humanism that can be traced back to the time of Hippocrates.

This apparent conflict between market forces and humanistic ethics is not limited to Western cultures. Ho et al. (2011) in a Taiwanese study proposed an approach to building a framework for medical professionalism that incorporated historical and sociocultural contexts. In doing so, they challenged the universal applicability of the Western framework of medical professionalism and proposed a process to build a professionalism framework that reflected the cultural heritage and the values of local stakeholders in Taiwan. The framework differs from the Western framework in the centrality of self-integrity and the harmonization of personal and professional roles. In response to the value their society places on 'integrity', they propose that their model should include this virtue as the foundation of all medical professionalism. They argue that without this virtue, it is not possible to achieve any other aspect of professionalism.

This emphasis on integrity found echoes in the current study: a nurse participant remarked:

> *"I tell all my colleagues that your integrity shows your professionalism. Don't ever lose your integrity or else you will lose everything, respect, honor, dignity and everything that comes with it."(NRDF7)*

Nevertheless, there are other forces at work within the culture, at least in mainland China. Hsiao (2008p. 949) observes that,

> *"…an unfettered market approach in China has reduced access to care, increased patients' financial burden, and reduced emphasis on prevention and may have caused declines in quality and outcomes. A major driving force was that perverse incentives altered physicians' behavior toward self-interest at the expense of patients, even where professional ethics dictated otherwise. Other nations, including India, are grappling with the profit motive and its consequences. Chinese leaders are attempting to deal with these problems by expanding public investment and reducing perverse incentives. However, profit motives remain a powerful, potentially offsetting feature of a reformed system."*

An awareness of this conflict of motivation was identified in the current study. The Pakistani respondents frequently lamented that the increasing commercial interests of the healthcare professionals and the industry are affecting the professionalism movement negatively in the country and are the strongest driving force in moving health professionals away from their values, moral belief systems and even centuries-old established traditions of honor, integrity, self-sacrifice for duty, responsibility and care for others and their needs. They argue that there is a rise in self-interest amongst health professionals at the expense of altruism and integrity and this they believe is largely financially driven. One respondent said,

> *"Doctors are becoming money-making machines at the expense of patient care and honesty. They are losing all respect in public." (PTAM1)*

Patient-centred or paternalistic?

The UK General Medical Council in its document *Tomorrow's Doctors* identifies certain basic competencies that define professionalism and are required for practice by physicians (Simpkin & Walesby, 2017). By the end of training, medical students in the UK and elsewhere are expected to behave professionally according to a range of ethical principles, including respect for all patients and colleagues, acknowledging their ethical responsibilities towards patients, and placing patient safety at the center of care (Simpkin & Walesby, 2017; Inui, 2003; New South Wales Medical Board, 2005). This argument presents the rationale of the patient-centered model of healthcare delivery and professionalism being practised in the UK.

The region of origin of the current study has a rich and long history of British and central European influence on all aspects of life during the long era of colonization and Pakistan still follows the British system of education in at least the medical field. Postgraduate education and training is structured along the same lines as in UK. Much of the values and belief system taught and learned throughout the continuum of education relates to

that in UK and this is further strengthened by the fact that up till quite recently, the majority of senior professionals were trained in the UK and returned to their native country to practise and teach. They brought back with them values and belief systems adopted from Britain and acted as role models for their peers and juniors. Theirs was not a commercial model of professionalism.

There are however differences in understanding largely based on the differences in context, workload, lack of external regulation, the socioeconomic state of the country and the prevailing culture that still is largely rural and orthodox and is based on power and authority. These conditions are reflected in the way the patient-physician relationship is established on unequal physician-favoured grounds and the growing degree of apathy and lack of sympathy exhibited by professionals in this country in the face of increasing demands placed on the healthcare services and dwindling wages. One faculty member remarked thus:

> *"In Pakistan, doctors are overworked. Overwork leads to incidences where professionalism is neglected. This in turn becomes habitual and a certain degree of apathy also creeps in especially when one doesn't get paid much for all the effort one puts in."(FMDM3)*

Alternative medicinal practices, lack of following SOPs and procedures and quick-fix techniques to save time and generate rapid patient turnover in both the private and public sector affects patient outcomes. In the end the practice of professionalism in Pakistan is perhaps as distant from patient-centeredness as the same practice is closer to it in the UK. Lack of education amongst the public, both in general and also related to their rights as human beings and patients, further compounds the problem and strengthens the aura of superiority that health professionals bask in. A quote from a patient illustrates the point quite vividly thus:

> *"We are not literate and we do not understand what the doctor knows or wants to do to us. We just tell him the problem and we feel the doctor who asks and explains the least and does his bit to get us better is the best doctor."(PTBF3)*

While a faculty member on culture and professionalism added:

> *"Our culture and way public expects doctors to behave is different from UK where I have worked for 3 years as well. In UK, patient has rights, you have to treat patients with respect and dignity. Here public allows doctors to humiliate them and strip them off their dignity and they get impressed by this, it's the feudal culture and mindset here in Pakistan." (FCFF1)*

Such a state of affairs lends itself to an environment wherein not much in terms of professionalism is expected of a health professional and neither is it provided. Similar conditions exist in much of Latin America and Africa, in particular Sub-Saharan Africa (Day et al., 2014; Louw & Duvenhage, 2016; 2017; Johnson-Jennings, Walters & Little, 2018). In these countries as in ours, increasing workload and dwindling resources strains the idealistic pre-conceptualization of medical professionalism and requires professionalism to be looked at through a very different lens, that of maximum service delivery while struggling to maintain best practices.

The influence of religion:

Religious beliefs clearly have an important role to play in understanding how professionalism is viewed within a society. The Middle East is geographically, culturally and socio-politically a distinct region and perhaps the only thing that it shares in common with Pakistan is religion - that, and the fact that a large number of Pakistani health professionals are attracted to the tax-free, high pay-package market in the healthcare sector in the Middle East and actively seek employment there. Much work on the subject of professionalism has been done recently in this region.

In another Arabian study Al-Eraky et al. (2014) identified eight professionalism traits which they coupled into four themes: dealing with self, dealing with tasks, dealing with others and dealing with God. Self-accountability and self-motivation were interpreted from a

faith viewpoint as ‘‘taqwa’’ and ‘‘ehtesab’’, respectively, in Arabic. These four themes they call gates. This four-gate model is interesting in being influenced by the local culture, societal values and religious beliefs. It is the last of the three, religious beliefs that sets the perception of professionalism of the respondents in their study apart from reported literature from the UK (but not the culturally religious society in USA) for example and compares well with the responses of the participants in this study:

> *“Religious beliefs affect patient expectations and the nature of healthcare delivery in our country which will be difficult for someone from UK to understand. One reason health professionals get away with murder in terms of unprofessional behaviour is because they can attribute any ill effect of their mismanagement, quite wrongly, to Allah’s will which is accepted by poor, feeble-minded illiterate patient and his attendants” (FCAF2)*

The quote above illustrates how religious beliefs may lead to fatalism and possibly through that to lack of accountability of all stakeholders concerned at all levels. A patient on the subject stated:

> *“Allah gives and Allah takes away…we cannot blame a doctor if someone died, it was Allah’s will.”(PTCF2)*

This belief in the Divine is not specific to the Eastern or Muslim culture but is also present in the US and certain African and Eastern European countries, where religion is ingrained in the culture and is practised as a way of life. The influence of quackery and religious cult-based healthcare is rife within Eastern Europe (Bărbulescu, 2011; Bărbulescu, 2015). These conditions are quite similar to those in Pakistan as one participant remarked:

> *“The population in Pakistan is mostly rural, illiterate and believes in the cult, taboos, religious and cultural remedies in treatment of illness. They have limited access to especially in the rural areas to clean water and sanitation. They live unhygienically. They are preyed upon by pseudo-religious healers and cult-doctors and expect the same kind of treatment from the doctors if ever they get to visit one. To them all ailment is a punishment from God and not because of following unhygienic living practices.” (PMAM5)*

But there is another side to it: religious belief manifests itself in our Pakistani health professionals in attitudes such as being content with one's lot, fear of divine retribution and a commitment to one's profession as a means to earn salvation. This is elucidated in the following quote:

> *"I work, knowing that my every action is being watched by Allah and I am to be held accountability for my actions on the Day of Judgment. I am content that Allah will reward me for my good deeds and my good treatment of His beings on earth." (FMCF4)*

This belief system should be considered a strength in promoting professionalism in Pakistan and similar countries, where measures of external accountability are shallow and where the public is largely left at the mercy of health professionals' choices. A strong sense of Divine accountability helps in keeping moral standards high and in promoting professional behaviour in such cultures.

In Japan, the profession of healthcare is strongly affected by the beliefs and ideas that they derive from Bushido (Nishigori et al., 2014). While not strictly a religion, the concept operates in a similar way. Nishigori et al. (2014) explain the seven main virtues of Bushido: rectitude (*gi*), courage (*yu*), benevolence (*jin*), politeness (*rei*), honesty (*sei*), honor (*meiyo*), and loyalty (*chugi*). All these seven virtues have been identified by the respondents in the current study and literature elsewhere, as is clear from the illustrative quotes provided in the previous sections. Just as these virtues are firmly intertwined with the Japanese culture and way of life, they are similarly a part of culture and tradition within the Pakistani society where they are linked with religious beliefs. A quote from a patient illustrates the point:

> *"One lives by a code and dies by a code. This code was passed on to me by my father and to him by his father and so on. Be fair, live honestly, give freely, respect dignity of others, work with integrity, never give up honour and treat your family well and your reward shall be a content life and heaven in the afterworld." (PTCM2)*

The need for training in professionalism - and the type of training needed:

Participants in our study showed considerable support for the need to train medical students in professionalism, as well as acknowledging an ongoing requirement for continuing medical education. There was little detail, however, about what this training should consist of. In a study comparing recommended sanctions for lapses in professionalism of undergraduate medical students in a Saudi Arabian and a Scottish medical school, Sattar & Roff (2016) identified that Saudi students were more lenient than their Scottish counterparts in one-third of the cases of theses lapses in recommending sanctions. They argue that, whereas today's doctors need to act according to professional values more than ever before, medical professionalism is perceived and expressed with respect to local customs, beliefs and cultures; and that differences in the perception of professionalism may be the function of different national and regional cultures.

Adkoli, Al-Umran, Al-Sheikh, Deepak & Al-Rubaish (2011), eliciting the views of final year medical students, interns, and residents in Saudi Arabia, identified lack of professionalism training, poor role models, lack of incentives towards professionalism acquisition and active demonstration of the same and a poor attitude towards professionalism that tended to promote non-professional behavior. Interestingly various stakeholders in the current study also pointed towards similar trends in Pakistan. One medical student on the subject of training and role modeling in professionalism remarked:

> *"First of all professionalism as a subject is neither taught nor assessed and secondly, we see our seniors do all sorts of unprofessional behavior all day long like for example operating without taking proper consent, or inappropriate exposure of patient in public or discussing patient problems in public."(MSFF5)*

In a study of nineteen individuals from eleven countries, Cruess, Cruess & Steinert (2010b, p.371) noted 'differences…in the role of the professional, which of course must

reflect national differences in the social contract in health care'. They concluded that these differences must be respected when teaching programs are developed to teach professionalism. Cruess, Cruess & Steinert (2010a, p.357) argue that

> 'the role of the healer is universal, but how professionalism is expressed will differ between countries and cultures due to differences in their social contracts. When professionalism is taught, it should be related to the different cultures and social contracts, respecting local customs and values'.

This view is supported by the participants of our focus group discussions. One of the physicians commented:

> *"Professionalism is contextual in my opinion. The requirements for being a good professional will vary from context to context. The doctor should be able to change his behaviour and attitudes according to the context. Show flexibility and adaptability……there are situations which require one way to handle the patient and a similar problem may be handled in an different way depending on various factors, like public or private setting, urban or rural or in Pakistan and outside Pakistan" (FCFF10)*

Another commented on situational competence in a quote as reproduced below:

> *"Doctor should be competent and should adopt methodology according to circumstances....." (FCCM10)*

One of the policy makers in the focus group discussions remarked:

> *"We need to train healthcare providers to be culturally competent, to understand what is appropriate in one cultural setting and what is not?.....One should understand the cultural nuances of the profession." (PMCF5)*

6.3 Summary: The influence of culture on conceptions of professionalism

Grus *et al*. (2018) argue that definitions of professionalism have been largely derived from Western (Anglo-Saxon) attributes and values associated with medical professionalism. However, Al-Rumayyan *et al*. (2017) in a narrative overview of studies that address professionalism in non-Western cultures in the period 2002–2014, Seys *et al*. (2013) in an

extensive search conducted in electronic databases Medline, Embase and Cinahl from the start date of each database until September 2010, Cruess, Cruess & Steinert (2010a) in their commentary *Linking the teaching of professionalism to the social contract: A call for cultural humility* and Freidson (1999) in *Theory of professionalism: Method and substance*, all identify professionalism as a complex, multidimensional *social* construct. Al-Eraky & Chandratilake (2012), validating the components of professionalism framework of the American Board of Internal Medicine (ABIM) to the Arabian context, and Cruess, Cruess & Steinert (2010b) support the importance of contextual, geographical and cultural considerations in any discussion regarding professionalism.

This study argues that an apparently universal concept, medical professionalism, can only be understood as it plays out within a specific social and cultural context. At the same time medical professionalism cannot be broadly explained in terms of cultural context alone. Every patient – healthcare provider encounter needs to be considered to occur in a unique context of culture both of society and the organization, as well as the cultural background of individuals involved in the encounter. Moreover the situation, resources, language, space and time as well as a host of other factors influence the outcomes of that professional encounter. Every single professionalism encounter is therefore culturally, socially, contextually unique and cannot be grouped together to relate to one particular cultural paradigm or the other.

Cardon (2008) claims that Hofstede's work is one of the most cited in the field of social sciences. Piller (2011) proposes that the concept of power distance is especially very popular in explaining cultural differences. Nazim & Wajidi (2016) used these dimensions to describe the national culture of Pakistan. They proposed that Pakistan is high on power distance and uncertainty avoidance, low on individualism and mediocre on masculinity and long-term orientation. However, such studies have been heavily criticized, mainly on account

of extrapolating the inferences drawn from data collected from a specific subset of the population that may very well not be representative of the entire country (Ly, 2013).

There may be some value in seeing some aspects of our findings in terms of Hofstede's power distance continuum – for example, the apparent preference of many patients for a more paternalistic model of the doctor-patient relationship. But this is too simplistic to give a consistent interpretation of the attitudes expressed by our participants, which recognize conflicting values and very specific constraints within the system on the expression of professionalism.

Pakistan is very far from being a monocultural country. This is not only because it is made up of diverse sub-cultures: it also has wide disparities of wealth and class, bringing with them very different attitudes and expectations, including those towards healthcare. In addition it has a mix of very disparate influences at the global level: on the one hand, an Islamic country which identifies itself with the Ummah, on the other, a member of the British Commonwealth with still lingering colonial influences; and through the media and international financial realities, also under heavy influence from the US and its free-market values. So it is hardly surprising that its people, particularly well-educated professionals, find themselves faced with dilemmas and conflicts in trying to work out what values they should hold to and how they should behave in their daily practice.

In this study the 530 respondents identified that broadly speaking professionalism requires possession of key knowledge and skills attributed to the profession and a set of attitudes and behaviours that allows the professional to practise his or her craft in a manner that serves the best needs of the society, the client and the profession. Our research findings support the evidence in the world literature that professionalism in all its attributes is a highly contextual phenomenon and varies from one situation to another. How this phenomenon plays out in any given setting is likely to be dependent on a host of internal and external

factors that have been discussed in detail in this thesis. At the same time professionalism is in a continuous state of evolution and its understanding keeps on changing within societies and cultures. This should not come as a surprise since the findings of this study are in congruence with the world literature in that professionalism is a social phenomenon. Social values, cultural norms and public views change and with it changes the understanding the professionals and the public have of this phenomenon.

6.4 Recommendations

That an idealistic conceptualization of professionalism and how it plays out within a certain cultural, socio-economic and power distance relationship background are quite distinct is a finding of this research study. Thus, professionalism is a highly contextual phenomenon and, apart from cultural influences, is also affected by the expectations of the different parties involved within any given setting. Individual expectations, lived experiences, taboos, socio-religious peculiarities, language amongst others affect the sense-making of this phenomenon by individuals and groups alike. The extent of regulations, accountability and autonomy of the profession and empowerment of the client and the society also affect professional practice. One man's professionalism might well be another's malpractice. And yet, researchers continue to seek out the one true meaning of professionalism and curricula continue to teach an idealistic conceptualization of the same. Accountability and regulation continue to serve a professional idealism that is difficult to identify in real practice. It is in this background that the following recommendations are made.

- Professionalism needs to be formally taught throughout the undergraduate and post graduate curriculum as well as to practising physicians through dedicated continuing professional development programs. Program developers may very well be justified in

including courses related to medical professionalism in the curriculum that are based on an ideal conceptualization of this phenomenon. However, they will do well to understand the varying cultural, socio-economic, religious taboos, situational and contextual peculiarities that affect professionalism. They must recognize that an idealistic teaching of professionalism is more often than not challenged in the real setting by factors cultural, situational and contextual.

- Looking at medical professionalism through a certain cultural and contextual lens can very well lead to 'cultural blindness' wherein cultural and contextual tolerance gives way to sclerosis in thought and rigidity in practice. It is therefore important that the curriculum incorporates this teaching of tolerance to cultural, situational and contextual peculiarities that might have an effect on professionalism and its understanding in any given setting.
- As many as possible of the typical challenges that healthcare workers will face in their professional practice need to be incorporated in the teaching and training of professionals and a discourse on these encouraged. This is particularly important in the training of undergraduate students who encounter these challenges in the hidden curriculum setting and in the practice of their role models. If not allowed to be brought into the formal curriculum, these challenges only lead to confusion and add to the stress the undergraduate students experience as they develop their professional identity.
- Similarly, in the graduate education and continuing professional development it is important that case-based education incorporating scenarios that promote a discussion on various aspects of professionalism in different cultural and contextual settings be encouraged. The culture of private practice and public service are two distinct areas where professionalism is frequently challenged in the same society and culture.

Undergraduate students will do well to be exposed to such challenges in their formative years rather than to be led blindly into them. Patient safety in the presence of immense workload in the public sector and the rising commercialization in the private practice setting are just two of the many examples that can form the basis of these cases used for training through evidence based discourse.

- The knowledge and skills related to a profession are but only two components of what professionalism encompasses. There are a host of other attributes and components, skills and knowledge regarding other subjects that promote professional practice. Therefore subjects like management, leadership, communication skill and sociology need to be incorporated in the curricula of both professional and pre-professional education. This is because one of the findings of this research study indicates that good management, leadership and communication skills, while understanding institutional, professional and societal culture and taboos, is important if professionalism is to be upheld.
- It is at the same time important that the curricula in primary, secondary and higher secondary education include teaching and training of behavior, attitudes and civic sense that helps develop a moral compass that is ethical and humanistic and is integrated within the personality of the individual. Laws and regulations by the government are enacted and exercised in manner that promote this morality and excellent behavior within the society. Here again teaching the ideal should be complemented with the challenges that ideal faces and why. Only then will we be able to provide to the profession in the undergraduate years a student whose moral compass is set right and aligned with that of the society in a direction that can only foster best professional practices.

- Professional regulatory bodies will have to do their part in ensuring that their regulations governing the profession are in the best interest of the clients they serve and in the interest of the profession and its practitioners. Accountability standards will need to be set high and enforced without prejudice and delay. It is important that these standards should reflect the cultural, socio-religious and economic constraints on practice and that the public and the practitioners are also made aware of the same.
- It is the duty of the profession and the government to empower its public so that they are aware of their rights and the rights of the physicians. When neither infringes on the rights of the other, conflicts in professionalism are less likely to arise. Dedicated awareness programs on electronic and social media could help empower the public to be made aware of challenges the physicians are facing in the current socio-economic and cultural settings, including ways of mitigating these in order to arrive at the best possible outcomes in a professional encounter with a healthcare provider.

At the same time healthcare providers should be protected by law against violence by clients and the public and the rights of the healthcare providers guarded by institutions and government. It will perhaps be prudent to include healthcare providers and patient group voices in the regulatory bodies, government and institutional boards so as to ensure that the regulations, laws and rights reflect the expectations of those that are directly involved. Mechanisms of social and moral support for physicians need to be devised and their wellbeing needs to be considered a high priority based on the fact that they represent a valuable commodity in a nation's infrastructure

6.5 The strengths and limitations of this study:

This research study has both strengths and limitations. I graduated from Pakistan completing my MBBS in 1997 and then went to work in tertiary care hospitals of both Pakistan and England while earning post-graduate qualifications from the respective countries, I was involved in teaching and training of health professions students in Pakistan and England. I am a medical educationist and already have a PhD in Medical Education. At the time of this research study I was working as professor of medical education and Pro-Vice Chancellor at one of the largest public sector health sciences universities in Pakistan. Thus, my background provided me with a positionality within the study that can be considered as a strength in many ways but also as a limitation.

Because of the status I held in the university and its 78 affiliate and constituent institutions, access to the stakeholders was all but guaranteed, but at the same time the same status might have resulted in at least some of the participants responding in ways that they believed would shield them from any perceived adverse institutional effects, while offering me the best explanations they could provide to my queries. Even though all participants were assured in writing and verbally that their responses would no bearing on their status, this is a limitation of the study in that I still believe my status could have influenced the participants.

Moreover, as a sole researcher, my own background and lived experiences could be considered another limitation of this study. As I have explained in chapter three of this thesis, although I tried my utmost to bracket my feelings, perceptions and understandings related to the research question while gathering and interpreting data, I must still admit that bracketing is a concept that is much easier said than done. My positionality and lived experiences might have influenced the interpretations. Then again, given my rich background in the area of research, this could also be considered one of the strengths of this study.

One might argue that one of the limitations of this study is that a scoping review of the literature evidence was carried out. Thus an overview of a potentially large and diverse body of literature rather than a systematic review collating empirical evidence from a relatively smaller number of studies pertaining to medical professionalism was presented. However, for a broad and complex topic like medical professionalism, a scoping review is quite acceptable as a means to synthesize research evidence, map existing literature on the topic and identify research gaps. Since scoping reviews generally include a greater range of study designs and methodologies than systematic reviews providing a descriptive overview of the reviewed material rather than a critical appraisal, a scoping review carried out in this study could very well be considered a strength rather than a limitation of this study.

One of the strengths of the study is the large number of the participants from different stakeholder groups, from different areas of a very diverse province, allowing for rich data to be accumulated and made available for comparison and triangulation.

It can be argued that the same strength could possibly also be a limitation of the study. With 38 FGDs, each with on average 11 participants, the data generated was certainly overwhelming. However, as detailed in this manuscript, by sticking carefully to the requirements of the methodological paradigm, maintaining a reflexive stance and an iterative process throughout the research process, this huge dataset was used to enhance the trustworthiness of the study and hence this can be counted as a strength of the study.

Another limitation is that FGDs only were used for direct data generation. FGDs were not followed by in-depth interviews. In-depth interviews were deliberately left out of the study design. Since FGDs were carried out with six different kinds of stakeholders in three distinct regions of the province, then at least twelve interviews would have been required for a single representation of a stakeholder group and a region and this would not have been ideal (Cresswell, 2013). To make the data generated through in-depth interviews credible at least

two to three interviews per stakeholder group per region would have been advisable. It was not possible to conduct 24-36 interviews.

Gender equality in numbers was maintained as much as possible in all FGDs. This could also be considered as a strength of the study.

The limitations of the study can thus be summarized as follows:

1. Population:

a. The population of the study included the stakeholders, that is, patients, physicians, allied health sciences and medical students, health administrators and policymakers, and nurses in the province of Punjab, Pakistan only. It was not possible to take a broader sample, including stakeholders from all regions of Pakistan and when comparing findings, a comparison with world literature only was made and stakeholders from other regions of the world were not directly included in this study.

b. The sample was gathered through requesting heads of institutions in a detailed telephone conversation and also through sending in a written request detailing objectives and procedures. However, it is clear that since the heads of institutions themselves were involved, some voices may have been left unheard in this study as heads might have excluded such individuals which they thought could provide a negative narrative regarding the phenomenon that could affect them or their institution.

2. Focus Group Discussions: The total number of focus group discussions conducted were thirty-eight across the entire province of Punjab involving various stakeholder groups. The number of group discussions far exceeded that recommended in literature for this type of study. The data collected is immense and the analysis took many months to complete. It became difficult at various stages during the research project to maintain sense of the data gathered. The sense-making process evolved over these months and required considerable reflective effort to stay on track as defined by the objectives of

the study. So many focus group discussions were carried out only to include a purposive sample from all areas of the province with a total population and area exceeding that of UK and the Republic of Ireland combined.

3. Participants of Focus Group Discussions: The participants were selected as per convenience based on locality and stakeholder group. The researcher tried to ensure maximum variability in terms of age, experience, gender and rank/status. However, no effort was made to define homogeneity or heterogeneity of the groups, other than their status as stakeholders, and therefore the analysis cannot make any claims towards gender or age differentiation in the findings.
4. Credibility: Participants were from various educational backgrounds and therefore it was difficult to ascertain if all could understand the debate and participate in it at an equal level. However, all efforts were made to ensure that all participants participated equally and understood the questions and the discussion.
5. Generalization: In order to generalize the findings of the study they have been compared and contrasted with literature on the subject from various parts of the world. In an ideal situation with unlimited time and resources a representative sample of all stakeholders from all regions of the world could have been taken. This however would have made the study more complex and the analysis even more difficult to handle and present by increasing further the number of the respondents.
6. Follow-up: The focus group discussions should ideally have been followed up with in-depth interviews of stakeholders to further explore the findings from the group discussions. However, time and resources did not permit this.

6.6 Further Research

One of the limitations of the study is that findings from focus groups have not been explored further in depth using interviews with stakeholders. It is proposed that another research study may be designed that explores these in further detail in order to help further contextualize the findings and validate the inferences made in the study. Moreover it is proposed that there should be further research looking at the actual teaching of professionalism in medical colleges, its short- and long-term effects, and how it could be improved and made more effective.

6.7 Conclusion

The three research questions we set out to answer at the beginning of this study were:

1. What are the perceptions of doctors, nurses, students, administrators and policymakers in Punjab, Pakistan, regarding medical professionalism?
2. How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in literature regarding sense-making by stakeholders in other regions of the world? and
3. How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

Following the discussion of findings in the last two chapters, it is evident that 'medical professionalism' is not a static, stable construct but rather dynamic, fluid and multidimensional. The construct could be likened to a living entity that has its tentacles attached to every aspect of our life-world - a sensitive organism that shifts and changes and reacts with changing contexts and situations. Like any living organism, it has the ability to grow and mature, assimilating and expanding; growing in stature and stability. It is vulnerable too, and can succumb to illness contracted from the environment, the culture and

its beliefs or from peers and role-models. Like any life-form, it can degenerate with disuse and deform with misuse. If the misuse is not checked, if the environment, situations and contexts are unfavorable, this misuse and the negative reinforcements can turn it into a monster, requiring remedial actions.

The scoping review of the literature carried out in the study and presented in chapter 2 of this thesis identified that there exist considerable variations in the understanding, both qualitative and quantitative, of the term or phenomenon called medical professionalism. And yet this understanding is crucial to the practice of the profession. It was identified that this variation in understanding largely exists on account of the inability of the individuals and groups involved with medical professionalism to come up with a consensus on what should be included within medical professionalism's larger framework and to what extent.

It became apparent by the end of this research that culture, societal values, norms, religious beliefs and economic factors amongst others affect the sense which individuals and groups make of professionalism. The phenomenon cannot be adequately represented by a linear, uni-dimensional model. Each stakeholder experiences the phenomenon from his or her own standpoint within the society, influenced by educational background, socio-economic status, the religious and cultural belief system, ideation based on past experiences and expectations formed, whether right or wrong. Collectively stakeholders' understandings define the perception that the society has of professionalism in any region and this perception varies from region to region because human beings, how they feel and what they believe in, varies from region to region. Moreover, this understanding changes with situation and context, thus each encounter with the phenomenon is unique and is set against the background of shifting expectations.

In the 20th century and earlier, professionalism was the 'elephant in the room' that no one wanted to discuss. It seems from the preceding study that understanding professionalism has now become similar to the parable of the 'blind men and the elephant' (Fig. 6.1). This story that originated from the Indian subcontinent describes a group of blind men trying to conceptualize an elephant. These blind men have never come across an elephant before in their lives and, now having found one, they try to conceptualise it by touching it and feeling and probing the beast. As they do so, each one of them feels a different part of the animal, and in doing so, based on their limited information and experience, each comes up with a different description of the animal. They then argue amongst themselves, maintaining that their own description is correct and that others are dishonest, less experienced or mistaken.

Each individual's experience is a true experience based on reality. Their blindness is like the blindness of monocultural awareness. It requires collaboration between cultures and a real effort to understand each other's' 'reality' to arrive at a more organic and holistic conception.

Up until quite recently, this too was the state in which an understanding of the phenomenon or construct 'professionalism', found itself in the world literature. Over the last decade or so, however, considerable progress has been made in conceptualizing 'professionalism'. Thus, medical professionalism, as already stated, is a dynamic and constantly evolving construct and to try to confine it within a single generic definition would be like saying all human beings are alike. This research study lays the foundation for further research in this area, especially in trying to understand how best to make professionalism encounters meaningful and satisfactory for all parties and stakeholders concerned.

Figure 6.1: The Blind Men and the Elephant

References

ABIM Foundation (2002). Medical professionalism in the new millennium: a physician charter. *Obstetrics and Gynecology*, **100**(1), 170.

Abbasi, M. H., Siddiqi, A. & Azim, R. U. A. (2011). Role of effective communications for enhancing leadership and entrepreneurial skills in university students. *International Journal of Business and Social Science*, **2**(10),242-250.

Abdel-Razig, S., Ibrahim, H., Alameri, H., Hamdy, H., Haleeqa, K. A., Qayed, K. I. & Fares, S. (2016). Creating a framework for medical professionalism: an initial consensus statement from an Arab nation. *Journal of Graduate Medical Education*, **8**(2), 165-172.

Abdullah, M. A., Mukhtar, F., Wazir, S., Gilani, I., Gorar, Z. & Shaikh, B. T. (2014). The health workforce crisis in Pakistan: a critical review and the way forward. *World Health Population,* **15**(3), 4-12.

Adkoli, B. V., Al-Umran, K. U., Al-Sheikh, M., Deepak, K. K. & Al-Rubaish, A. M. (2011). Medical students' perception of professionalism: a qualitative study from Saudi Arabia. *Medical Teacher*, **33**(10), 840-845.

Adom, D., Yeboah, A. & Ankrah, A. K. (2016). Constructivism philosophical paradigm: implication for research, teaching and learning. *Global Journal of Arts Humanities & Social Sciences.* **4**, 1-9.

Agar, M. & MacDonald, J. (1995). Focus groups and ethnography. *Human Organization*, **54**(1),78-86.

Aguilar, A., Stupans, I., Scutter, S. & King, S. (2013). Towards a definition of professionalism, in Australian occupational therapy: Using the Delphi technique to obtain consensus on essential values and behaviours. *Australian Occupational Therapy Journal*, **60**(3), 206-216.

Ahmed, R. N. & Ahmad, K. (2016). Impact of population on economic growth: A case study of Pakistan. *Bulletin of Business and Economics*, **5**(3), 162-176.

Ahmed, W. & Tufail, S. (2016). Oral assessment in medical education: time for change. *Pakistan Armed Forces Medical Journal,* **66**(2), 294-95.

Akhund, S., Shaikh, Z. A. & Ali, S. A. (2014). Attitudes of Pakistani and Pakistani heritage medical students regarding professionalism at a medical college in Karachi, Pakistan. *BMC Research Notes*, **7**(1), 150.

Al-Abdulrazzaq, D., Al-Fadhli, A. & Arshad, A. (2014). Advanced medical students' experiences and views on professionalism at Kuwait University. *BMC Medical Education*, **14**(1), 150.

Al-Ansari, A., Al-Khalifa, K., Al-Azzawi, M., Al-Amer, R., Al-Sharqi, D., Al-Mansoor, A. & Munshi, F. M. (2015). Cross-cultural challenges for assessing medical

professionalism among clerkship physicians in a Middle Eastern country (Bahrain): feasibility and psychometric properties of multisource feedback. *Advances in Medical Education and Practice*, ***6***, 509.

Al-Bannay, H., Jarus, T., Jongbloed, L., Yazigi, M. & Dean, E. (2013). Culture as a variable in health research: perspectives and caveats. *Health Promotion International*, **29**(3), 549-557.

Al-Eraky, M. M. & Chandratilake, M. (2012). How medical professionalism is conceptualised in Arabian context: a validation study. *Medical Teacher*, **34**(Sup1), S90–S95.

Al-Eraky, M. M., Donkers, J., Wajid, G. & van Merrienboer, J. J. (2014). A Delphi study of medical professionalism in Arabian countries: the Four-Gates model. *Medical Teacher*, **36**(Sup1), S8-S16.

Al-Rumayyan, A., Van Mook, W., Magzoub, M. E., Al-Eraky, M. M., Ferwana, M., Khan, M. A. & Dolmans, D. (2017). Medical professionalism frameworks across non - Western cultures: A narrative overview. *Medical Teacher*, **39**(Sup1), S8–S14.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, **10**(3), 378-395.

Anjum, M. U. (2018). Level of medical education in Pakistan. *Northwest Journal of Medical Sciences*, **2**(2), 59.

Anwar, M. I. & Humayun, A. (2015). Faculty development - looking through different lenses. *Pakistan Armed Forces Medical Journal,* **65**(1), 110-117.

Archer, J., de Bere, S. R., Nunn, S., Clark, J. & Corrigan, O. (2015). "No one has yet properly articulated what we are trying to achieve": a discourse analysis of interviews with revalidation policy leaders in the United Kingdom. *Academic Medicine*, **90**(1), 88-93.

Archer, M. S. (2003). *Structure, Agency and the Internal Conversation*. Cambridge: Cambridge University Press.

Archer, R., Elder, W., Hustedde, C., Milam, A. & Joyce, J. (2008). The theory of planned behaviour in medical education: a model for integrating professionalism training. *Medical Education*, **42**(8), 771-777.

Arnold, L. & Stern, D. T. (2006). *What is Medical Professionalism?* Oxford: Oxford University Press.

Arnold, L., Shue, C. K., Kalishman, S., Prislin, M., Pohl, C., Pohl, H. & Stern, D. T. (2007). Can there be a single system for peer assessment of professionalism among medical students? A multi-institutional study. *Academic Medicine*, **82**(6), 578-586.

Askew, D. A., Lyall, V. J., Ewen, S. C., Paul, D. & Wheeler, M. (2017). Understanding practitioner professionalism in Aboriginal and Torres Strait Islander health: lessons

from student and registrar placements at an urban Aboriginal and Torres Strait Islander primary healthcare service. *Australian Journal of Primary Health*, **23**(5), 446-450.

Astor, A., Akhtar, T., Matallana, M. A., Muthuswamy, V., Olowu, F. A., Tallo, V. & Lie, R. K. (2005). Physician migration: views from professionals in Colombia, Nigeria, India, Pakistan and the Philippines. *Social Science & Medicine,* **61**(12), 2492-2500.

Azmand, S., Ebrahimi, S., Iman, M. & Asemani, O. (2018). Learning professionalism through hidden curriculum: Iranian medical students' perspective. *Journal of Medical Ethics and History of Medicine*, **11**, 10.

Badsar, A., Taramsari, M. R., Hoseinpour, J. & Jahromi, S. K. (2012). Postgraduate Trainees' perception of the clinical learning environment at an Iranian Medical Sciences University. *Procedia-Social and Behavioral Sciences*, **46**, 1084-1090.

Bagchi, A. D., Af Ursin, R. & Leonard, A. (2012). Assessing cultural perspectives on healthcare quality. *Journal of Immigrant and Minority Health*, **14**(1), 175-182.

Baldwin, D. (2006). Two faces of professionalism. In K. Parsi & M.N. Sheehan (Eds.) *Healing as Vocation: A Medical Professionalism Primer*. London: Rowman & Littlefield.

Bărbulescu, C. (2018). *Physicians, Peasants and Modern Medicine: Imagining Rurality in Romania, 1860-1910.* Budapest: Central European University Press.

Bărbulescu, E. (2011). At the Edge of Modernity: Physicians, Priests and Healers (1940-1990). *Philobiblon: Transylvanian Journal of Multidisciplinary Research in Humanities*, **16**(2) 549-561.

Barilan, Y. M. (2009). Responsibility as a meta-virtue: truth-telling, deliberation and wisdom in medical professionalism. *Journal of Medical Ethics*, **35**(3), 153–158.

Basabe, N. & Ros, M. (2005). Cultural dimensions and social behavior correlates: Individualism-Collectivism and Power Distance. *International Review of Social Psychology*, **18**(1), 189-225.

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, **13**(4), 544-559.

Bebeau, M. J. (2002). The defining issues test and the four-component model: Contributions to professional education. *Journal of Moral Education*, **31**(3), 271-295.

Behar, L., Friedman, R., Pinto, A., Katz-Leavy, J. & Jones, H. W. G. (2007). Protecting youth placed in unlicensed, unregulated residential "treatment" facilities. *Family Court Review*, **45**(3), 399-413.

Beine, M., Docquier, F. & Rapoport, H. (2008). Brain drain and human capital formation in developing countries: winners and losers. *The Economic Journal*, **118**(528), 631-652.

Benbassat, J. (2019). Hypothesis: the hospital learning environment impedes students' acquisition of reflectivity and medical professionalism. *Advances in Health Sciences Education*, **24**(1), 185-194.

Bennett, M. J. (2017). Developmental model of intercultural sensitivity. *The International Encyclopedia of Intercultural Communication*, **1**, 10.

Bennett, J. M. & Bennett, M. J. (2004). *Developing intercultural sensitivity: An integrative approach to global and domestic diversity*. Thousand Oaks: Sage Publications.

Bentz, V. M. & Shapiro, J. J. (1998). *Mindful Inquiry in Social Research*. Thousand Oaks: Sage Publications.

Berger, P. L. (1963). *Invitation to Sociology: A Humanistic Perspective.* Garden City: Doubleday.

Berwick, D.M. (2016). Era 3 for medicine and health care. *Journal of the American Medical Association,* **315**(13), 1329–1330.

Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T. & Nass, D. (2014). Defining professionalism in medical education: a systematic review. *Medical Teacher*, **36**(1), 47-61.

Blank, L., Kimball, H., McDonald, W. & Merino, J. (2003). Medical professionalism in the new millennium: a physician charter 15 months later. *Annals of Internal Medicine*, **138**(10), 839-841.

Bleakley, A. (2010). Blunting Occam's razor: aligning medical education with studies of complexity. *Journal of Evaluation in Clinical Practice,* **16**(4), 849-855.

Blinman, T. (2017). *Competency Based Medical Education is Wrong for Surgery*. At: https://osf.io/kzrqp (Retrieved 30-04-2019).

Bloom, S. W. (2002). Professionalism in the practice of medicine. *Mount Sinai Journal of Medicine*, **69**(6), 398-403.

Bond, M. (1987). Chinese values and the search for culture-free dimensions of culture. *Journal of Crosscultural Psychology*, **18**,143–64.

Borrero, S., McGinnis, K., McNeil, M., Frank, J. & Conigliaro, R. (2008). Professionalism in residency training: is there a generation gap? *Teaching and Learning in Medicine*, **20**(1), 11-17.

Bokhari, D. W. (2019). *Medical colleges and doctors in Pakistan: too many or too few?* At: https://nation.com.pk/21-Sep-2019/medical-colleges-and-doctors-in-pakistan-too-many-or-too-few (Retrieved 14-03-2019).

Bourgois, P., Holmes, S. M., Sue, K. & Quesada, J. (2017). Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Academic Medicine* **92**(3), 299.

Bowen, H. (2018). *Investment in learning: The individual and social value of American higher education*. Philadelphia: Routledge.

Bourgeois-Law, G., Teunissen, P. W. & Regehr, G. (2018). Remediation in practicing physicians: current and alternative conceptualizations. *Academic Medicine*, **93**(11), 1638-1644.

Brainard, A. H. & Brislen, H. C. (2007). Learning professionalism: a view from the trenches. *Academic Medicine*, **82**(11), 1010-1014.

Branch, W. T. (2010). The road to professionalism: reflective practice and reflective learning. *Patient Education and Counseling*, **80(**3), 327-332.

Branch, W. T. (2015). Teaching professional and humanistic values: Suggestion for a practical and theoretical model. *Patient Education and Counseling*, **98**(2), 162–167.

Branch, W. T., Weil, A. B., Gilligan, M. C., Litzelman, D. K., Hafler, J. P., Plews-Ogan, M., ... & Pittman, J. R. (2017). How physicians draw satisfaction and overcome barriers in their practices: "It sustains me". *Patient Education and Counseling*, **100**(12), 2320-2330.

Brater, D. C. (2007). Infusing professionalism into a School of Medicine: perspectives from the Dean. *Academic Medicine*, **82**(11), 1094-1097.

Brennan, M. D. & Monson, V. (2014). Professionalism: good for patients and health care organizations. *Mayo Clinic Proceedings,* **89**(5) 644-652.

Brennan, N., Price, T., Archer, J. & Brett, J. (2019). Remediating professionalism lapses in medical students and doctors: A systematic review. *Medical Education*, **40**(3), 194-204.

Brinkman, W. B., Geraghty, S. R., Lanphear, B. P., Khoury, J. C., del Rey, J. A. G., DeWitt, T. G. & Britto, M. T. (2007). Effect of multisource feedback on resident communication skills and professionalism: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, **161**(1), 44-49.

Brint, S. (1996). *In an age of experts: The changing role of professionals in politics and public life*. Princeton, US: Princeton University Press.

Brody, H. & Doukas, D. (2014). Professionalism: a framework to guide medical education. *Medical Education*, **48**(10), 980-987.

Brookfield, S. (2009). Engaging critical reflection in corporate America. In J. Mezirow & E.W. Taylor (Eds.) *Transformative Learning in Practice: Insights from community, workplace and higher education* (pp.125-135). San Francisco: Jossey-Bass.

Bryce, M., Luscombe, K., Boyd, A., Tazzyman, A., Tredinnick-Rowe, J., Walshe, K. & Archer, J. (2018). Policing the profession? Regulatory reform, restratification and the emergence of Responsible Officers as a new locus of power in UK medicine. *Social Science & Medicine*, **213**, 98-105.

Bryden, P., Ginsburg, S., Kurabi, B. & Ahmed, N. (2010). Professing professionalism: are we our own worst enemy? Faculty members' experiences of teaching and evaluating professionalism in medical education at one school. *Academic Medicine*, **85**(6), 1025-1034.

Bryman, A. (2003). *Quantity and quality in social research* (Vol. 18). New Delhi: Routledge.

Burford, B., Morrow, G., Rothwell, C., Carter, M. & Illing, J. (2014). Professionalism education should reflect reality: findings from three health professions. *Medical Education*, **48**(4), 361-374.

Butani, L., Bogetz, A. & Plant, J. (2019). Illuminating exemplary professionalism using appreciative inquiry dialogues between students and mentors. *Medical Teacher*, **41**(3), 325–331.

Byrne, J. M., Loo, L. K. & Giang, D. W. (2015). Duty hour reporting: conflicting values in professionalism. *Journal of Graduate Medical Education*, **7**(3), 395-400.

Byrne, M. M. (2001). Evaluating the findings of qualitative research. *AORN Journal*, **73**(3), 703-703.

Callahan, D. (1996). The goals of medicine: setting new priorities [Special Supplement]. *Hastings Center Report*, **25**(6), S1–S26.

Camacho, D. (2016). Blurring boundaries: An emotionally aware caregiver, social worker, and researcher. *Qualitative Social Work*, **15**(5–6), 682–695.

Campbell, E. G., Rao, S. R., DesRoches, C. M., Iezzoni, L. I., Vogeli, C., Bolcic-Jankovic, D. & Miralles, P. D. (2010). Physician professionalism and changes in physician-industry relationships from 2004 to 2009. *Archives of Internal Medicine*, **170**(20), 1820-1826.

Campos-Castillo, C. & Anthony, D. (2019). Situated trust in a physician: patient health characteristics and trust in physician confidentiality. *The Sociological Quarterly*, **60**(4), 559-582.

Capitulo, K. L. (2009). Addressing disruptive behavior by implementing a code of professionalism to transform hospital culture. *Nurse Leader*, **7**(2), 38-43.

Cardon, P. W. (2008). A critique of Hall's contexting model: A meta-analysis of literature on intercultural business and technical communication. *Journal of Business and Technical Communication*, **22**(4), 399-428.

Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: what method for nursing? *Journal of Advanced Nursing*, **20**(4), 716-721.

Carrese, J. A., Malek, J., Watson, K., Lehmann, L. S., Green, M. J., McCullough, L. B., … Doukas, D. J. (2015). The Essential Role of Medical Ethics Education in Achieving Professionalism: The Romanell Report. *Academic Medicine*, **90**(6). 744-752.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum* **41**(5), 545-547.

Chakravarthy, B., ter Haar, E., Bhat, S. S., McCoy, C. E., Denmark, T. K. & Lotfipour, S. (2011). Simulation in medical school education: review for emergency medicine. *Western Journal of Emergency Medicine*, **12**(4), 461.

Chamberlain, J. M. (2015). *Medical regulation and revalidation: A critical introduction*. Bristol: Policy Press.

Chan, A. W. & Cheung, H. Y. (2016). Extraversion, individualism and M & A activities. *International Business Review*, **25**(1), 356–369.

Chandratilake, M., McAleer, S. & Gibson, J. (2012). Cultural similarities and differences in medical professionalism: a multi-region study. *Medical Education*, **46**(3), 257-266.

Chandratilake, M., McAleer, S., Gibson, J. & Roff, S. (2010). Medical professionalism: what does the public think? *Clinical Medicine*, **10**(4), 364-369.

Chard, D., Elsharkawy, A. & Newbery, N. (2006). Medical professionalism: the trainees' views. *Clinical Medicine*, **6**(1), 68–71.

Chaudry A. (2015) *PMDC bars admission to 17 medical colleges.* From The DAWN, Jul 2nd 2015. At: https://www.dawn.com/news/1191764. (Retrieved 10.12.2016).

Chee, Y. C. (1999). Early 21st century professional practice: Change and challenge. *Annals of the Academy of Medicine Singapore*, **28**(6), 890-894.

Chen, J., Xu, J., Zhang, C. & Fu, X. (2013). Medical professionalism among clinical physicians in two tertiary hospitals, China. *Social Science & Medicine*, **96**, 290-296.

Chinzer, N. & Russo, A. M. (2018). An exploration of employer perceptions of graduate student employability. *Education & Training*, **60**(1), 104-120.

Chretien, K. C. & Tuck, M. G. (2015). Online professionalism: A synthetic review. *International Review of Psychiatry*, **27**(2), 106-117.

Christianson, C. E., McBride, R. B., Vari, R. C., Olson, L. & Wilson, H. D. (2007). From traditional to patient-centered learning: curriculum change as an intervention for changing institutional culture and promoting professionalism in undergraduate medical education. *Academic Medicine*, **82**(11), 1079-1088.

Chudzikowski, K., Fink, G., Mayrhofer, W., Minkov, M. & Hofstede, G. (2011). The evolution of Hofstede's doctrine. *Crosscultural Management: An International Journal,* **18**(1), 10-20.

Clandinin, D. J. & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, CA: Jossey-Bass.

Clark, J., Spurgeon, P. & Hamilton, P. (2008). Medical professionalism: leadership competency-an essential ingredient. *International Journal of Clinical Leadership*, **16**(1), 3-9.

Clyde, J. W., Rodríguez, M. M. D. & Geiser, C. (2014). Medical professionalism: an experimental look at physicians' Facebook profiles. *Medical Education Online*, **19**(1), 23149.

Cobb, P. & Bowers, J. (1999) Cognitive and situated learning perspectives in theory and practice. *Educational Research*, **28**(2)**,** 4–15.

Cohen, A. & Kol, Y. (2004). Professionalism and organizational citizenship behavior: An empirical examination among Israeli nurses. *Journal of Managerial Psychology*, **19**(4), 386-405.

Cohen, L., Manion, L. & Morrison, K. (2011). Surveys, longitudinal, cross-sectional and trend studies. In L. Cohen, L. Manion,& K. Morrison, *Research Methods in Education, (7th Edn) (*pp. 261-4). Oxon: Routledge

Collins, K. & Nicolson, P. (2002). The meaning of 'satisfaction' for people with dermatological problems: Reassessing approaches to qualitative health psychology research. *Journal of Health Psychology*, **7**(5), 615-629.

Cormack, D.F.S. (Ed.) (1991) *The Research Process in Nursing* (2nd edn). Oxford: Blackwell Scientific.

Coulehan, J. (2005). Today's professionalism: Engaging the mind but not the heart. *Academic Medicine*, **80**(10), 892-898.

Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (3rd Edn). Thousand Oaks: Sage.

Creswell, J. W., Hanson, W. E., Clark Plano, V. L. & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, **35**(2), 236-264.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage.

Cruess, R. L. & Cruess, S. R. (1997). Teaching medicine as a profession in the service of healing. *Academic Medicine* **72**(11), 941-952.

Cruess, R. L. & Cruess, S. R. (2008). Expectations and obligations: professionalism and medicine's social contract with society. *Perspectives in Biology and Medicine*, **51**(4), 579–598.

Cruess, R. L., Cruess, S. R. & Johnston, S. E. (2000). Professionalism: an ideal to be sustained. *The Lancet*, **356**(9224), 156-159.

Cruess, R. L., Cruess, S. R., & Steinert, Y. (2016). *Teaching medical professionalism: supporting the development of a professional identity*. Cambridge: Cambridge University Press.

Cruess, S. R. & Cruess, R. L. (2016). Professionalism as a social construct: The evolution of a concept. *Journal of Graduate Medical Education*, **8**(2), 265-267.

Cruess, S. R., Cruess, R. L. & Steinert, Y. (2010a). Linking the teaching of professionalism to the social contract: A call for cultural humility. *Medical Teacher*, **32**(5), 357-359.

Cruess, S. R., Cruess, R. L. & Steinert, Y. (2010b). Teaching professionalism across cultural and national borders: lessons learned from an AMEE workshop. *Medical Teacher*, **32**(5), 371-374.

Currey, J., Massey, D., Allen, J. & Jones, D. (2018). What nurses involved in a Medical Emergency Teams consider the most vital areas of knowledge and skill when delivering care to the deteriorating ward patient. A nurse-oriented curriculum development project. *Nurse Education Today*, **67**, 77-82.

Currie, G., Lockett, A., Finn, R., Martin, G. & Waring, J. (2012). Institutional Work to Maintain Professional Power: Recreating the Model of Medical Professionalism. *Organization Studies*, **33**(7), 937–962.

Das, J., Woskie, L., Rajbhandari, R., Abbasi K. & Jha, A. (2018). Rethinking assumptions about delivery of healthcare: implications for universal health coverage. *British Medical Journal*, ***361***, 1716.

Dashti, R., Laakso, A., Niemelä, M., Porras, M. & Hernesniemi, J. (2009). Microscope-integrated near-infrared indocyanine green videoangiography during surgery of intracranial aneurysms: the Helsinki experience. *Surgical Neurology*, **71**(5), 543–550.

David-Barrett, E., Yakis-Douglas, B., Moss-Cowan, A. & Nguyen, Y. (2017). A bitter pill? Institutional corruption and the challenge of antibribery compliance in the pharmaceutical sector. *Journal of Management Inquiry*, **26**(3), 326–347.

Davies, A. (2017). Ethics, Professionalism, Rights, and Codes. In E. Shohamy, I. G. Or & S. May (Eds.), *Language Testing and Assessment* (pp. 397–415). Cham: Springer International Publishing.

Day, C. (2002). School reform and transitions in teacher professionalism and identity. *International Journal of Educational Research*, **37**(8), 677–692.

Day, D., Silva, D. K. & Monroe, A. O. (2014). The wisdom of indigenous healers. *Creative Nursing*, **20**(1), 37-46.

De Groot, E., Endedijk, M., Jaarsma, D., van Beukelen, P. & Simons, R. J. (2013). Development of critically reflective dialogues in communities of health professionals. *Advances in Health Sciences Education*, **18**(4), 627-643.

Deedar-Ali-Khawaja, R. & Khan, S. M. (2010). Trends of surgical career selection among medical students and graduates: a global perspective. *Journal of Surgical Education*, **67**(4), 237-248.

Delany, C. M. (2005). Respecting patient autonomy and obtaining their informed consent: ethical theory - missing in action. *Physiotherapy*, **91**(4), 197-203.

Dennis, A. A., Foy, M. J., Monrouxe, L. V. & Rees, C. E. (2018). Exploring trainer and trainee emotional talk in narratives about workplace-based feedback processes. *Advances in Health Sciences Education*, **23**(1), 75–93.

Denzin, N. K. (1997). *Interpretive ethnography: Ethnographic practices for the 21st century*. Thousand Oaks: Sage.

DeRosa, G. P. (2006). Professionalism and virtues. *Clinical Orthopaedics and Related Research*, **449**, 28-33.

Dewey J. (1938) *Experience and Education*. New York: Macmillan.

DiCicco-Bloom, B. & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, **40**(4), 314-321.

Dixon-Woods, M., Yeung, K. & Bosk, C. L. (2011). Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors. *Social Science & Medicine*, **73**(10), 1452-1459.

Dogra, N., Dogra, J. R., Betancourt, N., Park, E. R. & Sprague-Martinez, L. (2009). The relationship between drivers and policy in the implementation of cultural competency training in health care. *Journal of the National Medical Association*, **101**(2), 127-133.

Dorfman, P. & Howell, J. (1988) Dimensions of national culture and effective leadership patterns: Hofstede revisited. *Advances in International Comparative Management*, **3**(1), 127-150.

Doukas, D. J., McCullough, L. B. & Wear, S. (2012). Perspective: Medical education in medical ethics and humanities as the foundation for developing medical professionalism. *Academic Medicine*, **87**(3), 334-341.

Doukas, D. J., McCullough, L. B., Wear, S., Lehmann, L. S., Nixon, L. L., Carrese, J. A., ... &Kirch, D. G. (2013). The challenge of promoting professionalism through medical ethics and humanities education. *Academic Medicine*, **88**(11), 1624-1629.

Dovey, S. M., Meyers, D. S., Phillips, R. L., Green, L. A., Fryer, G. E., Galliher, J. M., ... &Grob, P. (2002). A preliminary taxonomy of medical errors in family practice. *BMJ Quality & Safety*, **11**(3), 233-238.

Duffy, M. E. (1987). Quantitative and qualitative research: antagonistic or complementary? *Nursing & Health Care,* **8**(6), 356.

Dugan, S. & Trompenaars, F. (1996). National culture and the values of organizational employees a dimensional analysis across nations. *Journal of Cross-Cultural Psychology*, **27**(2), 231-264.

Dugdale, L. S., Siegler, M. & Rubin, D. T. (2008). Medical professionalism and the doctor-patient relationship. *Perspectives in Biology and Medicine*, **51**(4), 547–553.

Duke, P., Cestone, C., Baranowski, A., Grosseman, S., Li, H., Gottlieb, D. & Novack, D. (2017). Using narratives to create a framework to analyze professional growth of third year medical students. *MedEdPublish*, ***6***, 1-13.

Eagly, A. H. & Riger, S. (2014). Feminism and psychology: Critiques of methods and epistemology. *American Psychologist*, **69**(7), 685.

Eidson-Ton, W. S., Rainwater, J., Hilty, D., Henderson, S., Hancock, C., Nation, C. L. & Nesbitt, T. (2016). Training medical students for rural, underserved areas: a rural medical education program in California. *Journal of Health Care for the Poor and Underserved*, **27**(4), 1674–1688.

Elhami, S., Saberi, K., Ban, M., Mousaviasl, S., Moadab, N. H. & Ghassemi, M. (2017). The Challenges of Implementation of Professional Ethics Standards in Clinical Care from the viewpoint of Nursing Students and Nurses. *World Family Medicine*, **15**(9), 149-153.

Elliott, D. D., May, W. I. N., Schaff, P. B., Nyquist, J. G., Trial, J., Reilly, J. M. & Lattore, P. (2009). Shaping professionalism in pre-clinical medical students: Professionalism and the practice of medicine. *Medical Teacher*, **31**(7), e295-e302.

Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, **38**(3), 215-229.

Ellis, M. R. & Campbell, J. D. (2005). Concordant Spiritual Orientations as a Factor in Physician–Patient Spiritual Discussions: A Qualitative Study. *Journal of Religion and Health*, **44**(1), 39–53.

Emden, C. & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice*, **4**(4), 206-212.

Emden, C. & Sandelowski, M. (1999). The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice*, **5**(1), 2.

Enkh-Amgalan, R. (2016). *The Indulgence and Restraint Cultural Dimension: A Cross-Cultural Study of Mongolia and the United States*. At: https://dc.etsu.edu/cgi/viewcontent.cgi?article=1354&context=honors (Retrieved 12-05-16)

Ennis, G., Happell, B., Broadbent, M. & Reid-Searl, K. (2013). The importance of communication for clinical leaders in mental health nursing: The perspective of nurses working in mental health. *Issues in Mental Health Nursing*, **34**(11), 814-819.

Eraut, M. (2000). Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology*, **70**(1), 113-136.

Erde, E. L. (2008). Professionalism's facets: ambiguity, ambivalence, and nostalgia. *Journal of Medicine and Philosophy*, **33(**1), 6-26.

Feeney, G. & Alam, I. (2003). New estimates and projections of population growth in Pakistan. *Population and Development Review*, **29**(3), 483-492.

Feld, J. J., Jacobson, I. M., Hézode, C., Asselah, T., Ruane, P. J., Gruener, N. … Chan, H. L. (2015). Sofosbuvir and velpatasvir for HCV genotype 1, 2, 4, 5, and 6 infection. *New England Journal of Medicine*, **373**(27), 2599–2607.

Ferlie, E., Fitzgerald, L. & Wood, M. (2000). Getting Evidence into Clinical Practice: An Organisational Behaviour Perspective. *Journal of Health Services Research & Policy*, **5**(2), 96–102.

Field, J., Ellis, J., Abbas, C. & Germain, P. (2010). Teaching and assessment of professional attitudes in UK dental schools–Commentary. *European Journal of Dental Education*, **14**(3), 133-135.

Fineberg, H. V. (2012). A Successful and Sustainable Health System — How to Get There from Here. *New England Journal of Medicine*, **366**(11), 1020–1027.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. Hoboken, NJ: John Wiley & Sons.

Flexner, A. (1936) *Universities: American, English, German*. London, UK: Oxford University Press

Fulu, E., Warner, X., Miedema, S., Jukes, R., Roselli, T. & Lang, J. (2009). *Pakistan Social and Living Standards Measurement Survey* (PSLM). At: http://www.pbs.gov.pk/content/pakistansocial-and-living-standards-measurement-survey-pslm-2008-09-provincialdistrict [Retrieved 12 Jan 2017].

Flowers, P., Larkin, M. & Smith, J. A. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Frankford, D. M., Patterson, M. A. & Konrad, T. R. (2000). Transforming practice organizations to foster lifelong learning and commitment to medical professionalism. *Academic Medicine*, **75**(7), 708-717.

Freidson, E. (1999). Theory of professionalism: Method and substance. *International Review of Sociology*, **9**(1), 117–129.

Freidson, E. (2001). *Professionalism, the third logic: On the practice of knowledge*. Chicago: University of Chicago Press.

Frich, J. C., Spehar, I. & Kjekshus, L. E. (2015). Professional identity and role transitions in clinical managers. *Journal of Health Organization and Management*, **29**(3), 353–366.

Friedman, V. J. & Bertoin-Antal, A. (2005). Negotiating reality: A theory of action approach to intercultural competence. *Management Learning*, **36**(1), 69-86.

Friesen, P. & Blease, C. (2018). Placebo effects and racial and ethnic health disparities: an unjust and underexplored connection. *Journal of Medical Ethics*, **44**(11), 774-781.

Fuller, S. R. & Aldag, R. J. (1998). Organizational Tonypandy: Lessons from a quarter century of the groupthink phenomenon. *Organizational Behavior and Human Decision Processes*, **73**(2-3), 163-184.

Geertz, C. (1973). *The Interpretation of Cultures.* New York: Basic Books.

General Medical Council (2009). *Tomorrow's doctors: outcomes and standards for undergraduate medical education.* Manchester, UK: General Medical Council.

Ghaffar, A., Zaidi, S., Qureshi, H. & Hafeez, A. (2013). Medical education and research in Pakistan. *The Lancet*, **381**(9885), 2234-2236.

Gherardi, S. (2005) *Organizational Knowledge: The Texture of Workplace Learning*. Malden, Mass: Blackwell.

Ginsburg, S. & Stern, D. (2004). The professionalism movement: Behaviors are the key to progress. *American Journal of Bioethics*, **4**(2), 14-15.

Ginsburg, S., Regehr, G. & Lingard, L. (2003). The disavowed curriculum. *Journal of General Internal Medicine*, **18**(12), 1015-1022.

Ginsburg, S., Regehr, G., Hatala, R., McNaughton, N., Frohna, A., Hodges, B., ... & Stern, D. (2000). Context, conflict, and resolution: a new conceptual framework for evaluating professionalism. *Academic Medicine*, **75**(10), S6-S11.

Glicken, A. D. & Merenstein, G. B. (2007). Addressing the hidden curriculum: understanding educator professionalism. *Medical Teacher*, **29**(1), 54-57.

Goffman, E. (2017). *Asylums: Essays on the social situation of mental patients and other inmates*. London: Routledge.

Goldberg, J. L. (2008). Humanism or professionalism? The white coat ceremony and medical education. *Academic Medicine*, **83**(8), 715-722.

Goldie, J., Schwartz, L., McConnachie, A. & Morrison, J. (2003). Students' attitudes and potential behaviour with regard to whistle blowing as they pass through a modern medical curriculum. *Medical Education*, **37**(4), 368-375.

Gondal, K. M., Khan, J. S. & Ahmed, A. (2015). Measuring professionalism in a residency program. *Biomedica*, ***31*(**3), 239-245.

Goss, M. E. (1963). Patterns of bureaucracy among hospital staff physicians. In E. Friedson (Ed.) *The Hospital in Modern Society* (pps. 170-194). Glencoe, Ill: Free Press.

Goswami, S. & Sahai, M. (2015). Problems and Challenges in Medical Education in India. *European Journal of Contemporary Education,* **11**(1), 31-37.

Graves, D. (1986). *Corporate culture: diagnosis and change: auditing and changing the culture of organizations*. London: Frances Pinter.

Greenburg, D. L., Durning, S. J., Cohen, D. L., Cruess, D. & Jackson, J. L. (2007). Identifying medical students likely to exhibit poor professionalism and knowledge during internship. *Journal of General Internal Medicine*, **22**(12), 1711-1717.

Griess, C. J. & Keat, J. B. (2014). Practice what we preach: Differentiating instruction and assessment in a higher education classroom as a model of effective pedagogy for early childhood teacher education candidates. *Journal of Early Childhood Teacher Education*, **35**(1), 98-109.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, **3**(1), 42-55.

Gruen, R. L., Pearson, S. D. & Brennan, T. A. (2004). Physician-citizens - public roles and professional obligations. *Journal of American Medical Association,* **291**(1), 94-98.

Grus, C. L., Shen-Miller, D., Lease, S. H., Jacobs, S. C., Bodner, K. E., Van Sickle, K. S., … Kaslow, N. J. (2018). Professionalism: A competency cluster whose time has come. *Ethics & Behavior*, **28**(6), 450-464.

Guba, E. G. & Lincoln, Y. S. (1989). *Fourth Generation Evaluation*. London: Sage.

Guba, E. G. & Lincoln, Y. S. (1990). Can there be a human science? *Person-Centered Review*, **5**(2), 130-154.

Guest, G., Namey, E., Taylor, J., Eley, N. & McKenna, K. (2017). Comparing focus groups and individual interviews: findings from a randomized study. *International Journal of Social Research Methodology*, **20**(6), 693-708.

Guraya, S. Y., Norman, R. I. & Roff, S. (2016). Exploring the climates of undergraduate professionalism in a Saudi and a UK medical school. *Medical Teacher*, **38**(6), 630-632.

Hafferty, F. W. (1998). Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine*, **73**(4), 403-407

Hafferty, F. W. (2006). Definitions of professionalism: a search for meaning and identity. *Clinical Orthopaedics and Related Research*, **449**, 193-204.

Hafferty, F. W. & Castellani, B. (2009). The hidden curriculum: a theory of medical education. In C. Brosnan & B.S.Turner (Eds.) *Handbook of the Sociology of Medical Education* (pp. 29–49). London: Routledge.

Hafferty, F.W. & Franks, R. (1994). The hidden curriculum, ethics teaching, and the structure of medical education. *Academic Medicine*, **69**(11), 861-871.

Hafferty, F. W. & McKinlay, J. B. (1993). *The changing medical profession: an international perspective*. Oxford: Oxford University Press.

Hafferty, F. W. & Tilburt, J. C. (2015). Fear, regulations, and the fragile exoskeleton of medical professionalism. *Journal of Graduate Medical Education*, **7**(3), 344-348.

Haidet, P. & Stein, H. F. (2006). The role of the student-teacher relationship in the formation of physicians. *Journal of General Internal Medicine*, **21**(1), 16-20.

Hammer, M. R. (2011). Additional cross-cultural validity testing of the Intercultural Development Inventory. *International Journal of Intercultural Relations*, **35**(4), 474-487.

Handler, R. (2003). Cultural property and culture theory. *Journal of Social Archaeology*, **3**(3), 353-365.

Harris, P. R., Sillence, E. & Briggs, P. (2011). Perceived threat and corroboration: key factors that improve a predictive model of trust in internet-based health information and advice. *Journal of Medical Internet Research*, **13**(3), e51.

Hassan, M. M. (2019). *Personality and Psychological Contracts: Mediating Roles of Epistemic Curiosity and Rule-Following Behavior with Moderating Role of Uncertainty Avoidance* (Doctoral dissertation, Capital University of Science and Technology, Islamabad).

Hendelman, W. & Byszewski, A. (2014). Formation of medical student professional identity: categorizing lapses of professionalism, and the learning environment. *BMC Medical Education*, **14**(1), 139.

Herr, K. D., Hanna, T. N. & Restauri, N. (2018). Cultivating physician character in diagnostic radiology through virtuous caring and collaborative professionalism. *Academic Radiology*, **25**(11), 1497-1502.

Herschkopf, M., Jafari, N. & Puchalski, C. (2017). Religion and spirituality in medical education. In M. Balboni & J. Peteet (Eds.) *Spirituality and Religion Within the Culture of Medicine: From Evidence to Practice* (p.195-201). Oxford: Oxford University Press.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, M. E., Swyers, J. P., Larson, D. B. & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal of the Theory of Social Behaviour*, **30**(1), 51–77.

Hilton, S. & Southgate, L. (2007). Professionalism in medical education. *Teaching and Teacher Education,* **23**(3), 265-279.

Hilty, D. M., Crawford, A., Teshima, J., Chan, S., Sunderji, N., Yellowlees, P. M., … Li, S.-T. (2015). A framework for telepsychiatric training and e-health: Competency-based education, evaluation and implications. *International Review of Psychiatry*, **27**(6), 569–592.

Ho, M. J., Gosselin, K., Chandratilake, M., Monrouxe, L. V. & Rees, C. E. (2017). Taiwanese medical students' narratives of intercultural professionalism dilemmas: exploring tensions between Western medicine and Taiwanese culture. *Advances in Health Sciences Education*, **22**(2), 429-445.

Ho, M. J., Yu, K. H., Hirsh, D., Huang, T. S. & Yang, P. C. (2011). Does one size fit all? Building a framework for medical professionalism. *Academic Medicine*, **86**(11), 1407-1414.

Ho, M. J., Yu, K. H., Pan, H., Norris, J. L., Liang, Y. S., Li, J. N. & Hirsh, D. (2014). A tale of two cities: understanding the differences in medical professionalism between two Chinese cultural contexts. *Academic Medicine*, **89(**6), 944-950.

Hoare, L. (2010). The cultural complexities of internationalisation: student and lecturer experiences in an offshore Australian programme. In P. Kell, & G. Vogle (Eds.), *Global Student Mobility in the Asia Pacific: Mobility, Migration, Security and Wellbeing of International Students*. Newcastle: Cambridge Scholars.

Hodges, B. D., Ginsburg, S., Cruess, R., Cruess, S., Delport, R., Hafferty, F., … Wade, W. (2011). Assessment of professionalism: Recommendations from the Ottawa 2010 Conference. *Medical Teacher*, **33**(5), 354–363.

Hoffman, L. A., Shew, R. L., Vu, T. R., Brokaw, J. J. & Frankel, R. M. (2017). The association between peer and self-assessments and professionalism lapses among medical students. *Evaluation & the Health Professions*, **40**(2), 219–243.

Hofstede, G. (1984). *Culture's consequences: international differences in work-related values*. Newbury Park, CA: Sage Publications [Abridged edition].

Hofstede, G. (1991) *Cultures and organizations - software of the mind*. New York: McGraw Hill

Hofstede, G. (1994). Management scientists are human. *Management Science*, **40**(1), 4–13.

Hofstede, G. (2001) *Culture's Consequences*. *Comparing Values, Behaviors, Institutions and Organizations across Nations* (2nd Ed.). Thousand Oaks: Sage Publications.

Hofstede, G. (2009). *Geert Hofstede cultural dimensions*. At: http://taylortraining.com/clients/mcc/Hofstede_Cultural_Dimension_Explained(external).pdf. (Retrieved 12-05-16)

Hofstede, G., Hofstede, G. J. & Minkov, M. (2010). *Cultures and Organizations: Software of the Mind* (3rd Ed.) New York: McGraw-Hill.

Hohenstein, C. & Lévy-Tödter, M. (2020). On International (Medical) Doctors' Professional Identity in a Multilingual Environment. In C. Hohenstein & M. Lévy-Tödter (Eds.) *Multilingual Healthcare* (pp. 235-283). Wiesbaden: Springer Gabler.

Holden, M. D., Buck, E., Luk, J., Ambriz, F., Boisaubin, E. V., Clark, M. A., … Spike, J. P. (2015). Professional identity formation: Creating a longitudinal framework through TIME (transformation in medical education). *Academic Medicine*, **90**(6), 761–767.

Holm, S. & Williams-Jones, B. (2006). Global bioethics–myth or reality? *BMC Medical Ethics*, **7**(1), 10.

Holmes, C. L., Harris, I. B., Schwartz, A. J. & Regehr, G. (2015). Harnessing the hidden curriculum: a four-step approach to developing and reinforcing reflective competencies in medical clinical clerkship. *Advances in Health Sciences Education*, **20**(5), 1355–1370.

Holtman, M. C. (2008). A theoretical sketch of medical professionalism as a normative complex. *Advances in Health Sciences Education*, **13**(2), 233-245.

Hoppe, R. B., King, A. M., Mazor, K. M., Furman, G. E., Wick-Garcia, P., Corcoran–Ponisciak, H. & Katsufrakis, P. J. (2013). Enhancement of the assessment of physician–patient communication skills in the United States medical licensing examination. *Academic Medicine*, **88**(11), 1670–1675.

Hsiao, W. C. (2008). When incentives and professionalism collide. *Health Affairs*, **27**(4), 949-951.

Huda, N. (2001). Admission procedure as predictor of performance in medical colleges. *Journal of the Pakistan Medical Association,* **51**(11), 380-380.

Hui, C. H. (1988). Measurement of individualism-collectivism. *Journal of Cross-Cultural Psychology*, **22**, 17–36.

Husserl, E. (1971). *Phenomenology* (Trans. R.E. Palmer). (Original published 1927 in Encyclopaedia Britannica). At: https://religiousstudies.stanford.edu/sites/g/files/sbiybj5946/f/publications/click-to-read-pdf6.pdf (Retrieved August 2, 2013).

Inkeles, A. & Levinson, D. J. (1969). National character: The study of modal personality and sociocultural systems. *The Handbook of Social Psychology*, **4**, 418-506.

Inui, T. S. (2003). *A flag in the wind: Educating for professionalism in medicine*. Washington, DC: Association of American Medical Colleges.

Irvine, D. (1999). The performance of doctors: the new professionalism. *The Lancet*, **353**(9159), 1174-1177.

Irvine, D. (2001). Doctors in the UK: their new professionalism and its regulatory framework. *The Lancet*, **358**(9295), 1807-1810.

Jack, H., Canavan, M., Ofori-Atta, A., Taylor, L. & Bradley, E. (2013). Recruitment and retention of mental health workers in Ghana. *PloS One*, **8**(2), e57940.

Jaeger, R. J. (2009). By increasing our commitment to professionalism, we can do better. *Wisconsin Medical Journal*, **108(**9), 431—434.

Jafarey, NA. (1986) Some problems of medical education. *Journal of the Pakistan Medical Association*, **36**, 2-17.

Jahan, F., Siddiqui, M. A., Al-Zadjali, N. M. & Qasim, R. (2016). Recognition of core elements of medical professionalism among medical students and faculty members. *Oman Medical Journal*, **31**(3), 196.

Jalil, A., Zakar, R., Zakar, M. Z. & Fischer, F. (2017). Patient satisfaction with doctor-patient interactions: a mixed methods study among diabetes mellitus patients in Pakistan. *BMC Health Services Research*, **17**(1), 155.

Jamal, A. A. (2009). Perception of Physicians Regarding the Prevalence of Unprofessional Behavior among Their Colleagues in a Tertiary Care Hospital in Saudi Arabia. *Journal of Taibah University Medical Sciences*, **4**(1), 94-107.

Jamal, M. (2014). Professional commitment among nurses as a moderator of job stress and job performance: an empirical examination in the Middle East. *Middle East Journal of Nursing*, **101**(1227), 1-9.

Jamshed, S.Q. (2014). Qualitative research method-interviewing and observation. *Journal of Basic and Clinical Pharmacy*, **5**(4), 87.

Janis, I. L. (1982). *Groupthink* (2nd Ed) Boston: Wadsworth.

Jauregui, J., Gatewood, M. O., Ilgen, J. S., Schaninger, C. & Strote, J. (2016). Emergency Medicine Resident Perceptions of Medical Professionalism. *The Western Journal of Emergency Medicine*, **17**(3), 355–361.

Javaid A. (2017). The future of medical education: Meeting the global standards. *Khyber Medical University Journal,* **9**(3):1-2.

Jefferys, S. & Faunce, T. (2007). Whistleblowing and scientific misconduct: renewing legal and virtue ethics foundations. *Medicine and Law: An International Journal*, **26**, 567–584.

Jha, V., Bekker, H. L., Duffy, S. R. G. & Roberts, T. E. (2006). Perceptions of professionalism in medicine: a qualitative study. *Medical Education*, **40**(10), 1027-1036.

Jha, V., Bekker, H. L., Duffy, S. R., & Roberts, T. E. (2007). A systematic review of studies assessing and facilitating attitudes towards professionalism in medicine. *Medical Education*, **41**(8), 822–829.

Jha, V., Mclean, M., Gibbs, T. J. & Sandars, J. (2015). Medical professionalism across cultures: A challenge for medicine and medical education. *Medical Teacher*, **37**(1), 74–80.

Johnson-Jennings, M., Walters, K. & Little, M. (2018). And [they] even followed her into the hospital: Primary care providers' attitudes toward referral for traditional healing practices and integrating care for indigenous patients. *Journal of Transcultural Nursing*, **29**(4), 354-362.

Jones, W. H. S. (1923). *Hippocrates: The Nature of Man 1* [an English translation of the original Greek]. London: Heinemann.

Joynt, G. M., Wong, W.-T., Ling, L. & Lee, A. (2018). Medical students and professionalism - do the hidden curriculum and current role models fail our future doctors? *Medical Teacher*, **40**(4), 395–399.

Jubb, P. B. (1999). Whistleblowing: a restrictive definition and interpretation. *Journal of Business Ethics*, **21**(1), 77-94.

Kalhoro, M. (2017). *Sheikh Zayed Women's Hospital faces shortage of beds, paramedics*. Dawn News November 2017. At: https://www.dawn.com/news/1370731 (Retrieved 13-05-2018)

Kapur, D. & Mehta, P.B. (2004). *Indian higher education reforms: From half- baked socialism to half-baked capitalism.* CID Working Paper No. 108. Boston, Mass.: Center for International Development at Harvard University.

Karimian, Z., Kojuri, J., Sagheb, M. M., Mahboudi, A., Saber, M., Amini, M. & Dehghani, M. R. (2014). Comparison of residents' approaches to clinical decisions before and after the implementation of Evidence Based Medicine course. *Journal of Advances in Medical Education & Professionalism*, **2**(4), 170.

Kasule, O. H. (2013). Medical professionalism and professional organizations. *Journal of Taibah University Medical Sciences*, **8**(3), 137-141.

Keillor, B. & Hult, G. (1999). A five-country study of national identity: implications for international marketing research and practice. *International Marketing Review*, **16**(1), 65–82.

Keshtkaran, V. & Moadab, N. (2013). Relationship between organizational effectiveness and the personnel managers' position of control in Shiraz University of Medical Sciences. *Journal of Advances in Medical Education & Professionalism*, **1**(2), 68-71.

Khalid, F. & Abbasi, A. N. (2018). Challenges faced by Pakistani healthcare system: Clinician's perspective. *Journal of College of Physicians and Surgeons,* **28**, 899–901.

Khan, A.S. (2016). *Scope of Medical Colleges in Private Sector.* At: http://ayubmed.edu.pk/JAMC/PAST/16-1/AJKhan.htm (Retrieved 23-01-17).

Khan, J. S., Biggs, J. S., Tabasum, S. & Iqbal, M. (2012). Assessment in medical education in Pakistan: evaluating evaluation. *Biomedical*, **28**(1), 88-94.

Khan, J. S., Biggs, J. S. & Mubbashar, M. H. (2011). Evaluation techniques in Punjab, Pakistan: eight years of reforms in health professional education. *Journal of Ayub Medical College Abbottabad,* **23**(1), 154-158.

King, D. E. & Bushwick, B. (1994). Beliefs and attitudes of hospital inpatients about faith healing and prayer. *Journal of Family Practice*, **39**(4), 349–353.

Kinghorn, W. A. (2010). Medical education as moral formation: an Aristotelian account of medical professionalism. *Perspectives in Biology and Medicine*, **53**(1), 87-105.

Kinghorn, W. A., McEvoy, M. D., Michel, A. & Balboni, M. (2007). Professionalism in modern medicine: does the emperor have any clothes? *Academic Medicine*, **82**(1), 40-45.

Kirby, S. & McKenna, K. (1989). *Experience, Research, Social Change: Methods from the Margins*. Toronto: Garamond Press.

Kirkpatrick, I., Hartley, K., Kuhlmann, E., & Veronesi, G. (2015). Clinical Management and Professionalism. In E. Kuhlmann, R. H. Blank, I. L. Bourgeault & C. Wendt (Eds.), *The Palgrave International Handbook of Healthcare Policy and Governance* (pp. 325–340). London: Palgrave Macmillan UK.

Kluckhohn, C. K. M. & Kluckhohn, R. (1962). *Culture and behavior: Collected essays of Clyde Kluckhohn*. Glencoe: Free Press.

Koch, T. & Harrington, A. (1998). Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing*, **28**(4), 882-890.

Konrad, T. R., Williams, E. S., Linzer, M., McMurray, J., Pathman, D. E., Gerrity, M., ... & Douglas, J. (1999). Measuring physician job satisfaction in a changing workplace and a challenging environment. *Medical Care*, **37**(11), 1174-1182.

Krause, E. A. (1999). *Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present*. London: Yale University Press.

Krueger, R. A. & Casey, M. A. (2009). *Focus groups: a practical guide for applied research*. Los Angeles, CA: Sage.

Laland, K. N. & Hoppitt, W. (2003). Do animals have culture? *Evolutionary Anthropology: Issues, News, and Reviews*, **12**(3), 150-159.

Lang, T. A., Hodge, M., Olson, V., Romano, P. S. & Kravitz, R. L. (2004). Nurse–patient ratios: a systematic review on the effects of nurse staffing on patient, nurse employee, and hospital outcomes. *Journal of Nursing Administration*, **34**(7), 326-337.

Latham, S. R. (2002). Medical professionalism. *Mt Sinai Journal of Medicine* **69**, 363-9.

Latif, M. Z. & Wajid, G. (2018). Reforming medical education in Pakistan through strengthening Departments of Medical Education. *Pakistan Journal of Medical Sciences,* **34**(6), 1439.

Lave, J. & Wenger, E. (1991) *Situated Learning: Legitimate Peripheral Participation*. New York, NY: Cambridge University Press.

Leasure, E. L., Jones, R. R., Meade, L. B., Sanger, M. I., Thomas, K. G., Tilden, V. P., … Warm, E. J. (2013). There Is no "I" in teamwork in the patient-centered medical home: defining teamwork competencies for academic practice. *Academic Medicine*, **88**(5), 585-592.

Leffel, G. M., Oakes-Mueller, R. A., Curlin, F. A. & Yoon, J. D. (2015). Relevance of the rationalist–intuitionist debate for ethics and professionalism in medical education. *Advances in Health Sciences Education*, **20**(5), 1371–1383.

Lesser, C. S., Lucey, C. R., Egener, B., Braddock, C. H., Linas, S. L. & Levinson, W. (2010). A behavioral and systems view of professionalism. *Journal of American Medical Association*, **304**(24), 2732-2737.

Li, L. C., Grimshaw, J. M., Nielsen, C., Judd, M., Coyte, P. C. & Graham, I. D. (2009). Evolution of Wenger's concept of community of practice. *Implementation Science*, **4**(1), 11.

Linville, D., Lambert-Shute, J., Fruhauf, C. A. & Piercy, F. P. (2003). Using participatory focus groups of graduate students to improve academic departments: A case example. *The Qualitative Report*, **8**(2), 210-223.

Lopez, K. A. & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, **14**(5), 726-735.

Louw, G. & Duvenhage, A. (2016). How and why bewitching and wickedness are created and maintained within small, specific segments of the South African population, *Journal for Cultural Studies,* **36**(9), 231-236.

Louw, G. & Duvenhage, A. (2017). The South African traditional health practitioner as a beneficiary of and provider to medical funds and schemes through the traditional health practitioners Act (Act No 22, 2007): A present-day perspective. *Australasian Medical Journal (Online)*, **10**(1), 24.

Lu, L. (2006). “Cultural fit": individual and societal discrepancies in values, beliefs, and subjective well-being. *Journal of Social Psychology*, **146**(2), 203-221.

Ly, A. (2013). A critical discussion of Hofstede’s concept of Power Distance. *Journal of Professional Communication,* **28**, 51-66.

Lynch, D. C., Surdyk, P. M. & Eiser, A. R. (2004). Assessing professionalism: a review of the literature. *Medical Teacher*, **26**(4), 366–373.

Mampane, R. & Huddle, C. (2017). Assessing the outcomes of school-based partnership resilience intervention. *South African Journal of Education*, **37(**1). 1-13.

Mann, K. V., Ruedy, J., Millar, N. & Andreou, P. (2005). Achievement of non-cognitive goals of undergraduate medical education: perceptions of medical students, residents, faculty and other health professionals. *Medical Education*, **39**(1), 40-48.

Marcum, J. A. (2019). Professing clinical medicine in an evolving health care network. *Theoretical Medicine and Bioethics*, **40**(3), 197-215.

Marmor, T. R. (2007). *Fads, fallacies and foolishness in medical care management and policy*. Singapore: World Scientific.

Marmor, T. R. & Freeman, R. (2009). *Comparative Studies and the Politics of Modern Medical Care*. London: Yale University Press.

Marmor, T. R. & Gordon, R. W. (2014). Commercial pressures on professionalism in American medical care: From Medicare to the Affordable Care Act. At: https://www.ncbi.nlm.nih.gov/pubmed/25565609. (Retrieved 13-06-16).

Marmor, T. R. & Sullivan, K. (2015). Medicare at 50: why Medicare-for-all did not take place. *Yale Journal of Health Policy, Law and Ethics*, **15**, 141.

Marrero, I., Bell, M., Dunn, L. B. & Roberts, L. W. (2013). Assessing Professionalism and Ethics Knowledge and Skills: Preferences of Psychiatry Residents. *Academic Psychiatry*, **37**(6), 392–397.

Martimianakis, M. A., Maniate, J. M. & Hodges, B. D. (2009). Sociological interpretations of professionalism. *Medical Education*, **43**(9), 829-837.

Martin, G. P., Armstrong, N., Aveling, E.-L., Herbert, G. & Dixon-Woods, M. (2015). Professionalism Redundant, Reshaped, or Reinvigorated? Realizing the "Third Logic" in Contemporary Health Care. *Journal of Health and Social Behavior*, **56**(3), 378–397.

Marton, G. E., McCullough, B. & Ramnanan, C. J. (2015). A review of teaching skills development programmes for medical students. *Medical Education*, **49**(2), 149-160.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, **50(**4), 370.

Matveevskii, A., Moore, D. L. & Samuels, P. J. (2012). Competency and professionalism in medicine. *The Clinical Teacher*, **9**(2), 75-79.

Maza, Y., Shechter, E., PurEizenberg, N., Segev, E. G. & Flugelman, M. Y. (2016). Physician empowerment programme; a unique workshop for physician-managers of community clinics. *BMC Medical Education*, **16**(1), 269.

McCammon, S. D. & Brody, H. (2012). How Virtue Ethics informs medical professionalism. *HEC Forum*, **24**(4), 257–272.

McCort, D. & Malhotra, N.K. (1993). Culture and consumer behavior: toward an understanding of cross-cultural consumer behavior in international marketing. *Journal of International Consumer Marketing,* **6**(2), 91–127

McCulloch, P. (2006). Surgical professionalism in the 21st century. *Lancet*, **367**(9505), 177–181.

McGurgan, P. M., Olson-White, D., Holgate, M. & Carmody, D. (2010). Fitness-to-practise policies in Australian medical schools—are they fit for purpose? *Medical Journal of Australia*, **193**(11), 665.

McSweeney, B. (2001). The fallacy of national culture identification. *Human Relations*, **55**(1),89-118.

Mechanic, D. (2008). Rethinking medical professionalism: the role of information technology and practice innovations. *The Milbank Quarterly*, **86**(2), 327-358.

Mehrabian, A. & Ferris, S. R. (1967). Inference of attitudes from nonverbal communication in two channels. *Journal of Consulting Psychology*, **31**(3), 248.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass Publishers

Mezirow, J. & Taylor, E. W. (2009). *Transformative learning in practice: Insights from community, workplace and higher education*. Hoboken, NJ: John Wiley & Sons.

Miles, M. B., Huberman, A. M., Huberman, M. A. & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks: Sage.

Miller, F. G. & Brody, H. (1995). Professional Integrity and Physician-Assisted Death. *Hastings Center Report*, **25**(3), 8-17.

Mills, J., Bonner, A. & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, **5**(1), 25-35.

Moazam, F., Jafarey, A. M. & Shirazi, B. (2014). To donate a kidney: public perspectives from Pakistan. *Bioethics*, **28**(2), 76-83.

Moekotte, P. B. F., Brand-Gruwel, S., Ritzen, H. T. M. & Simons, P. R. J. (2015). Early school leavers' attitudes towards online self-presentation and explicit participation. *Computers in Human Behavior*, **49**, 171-184.

Monrouxe, L. V. & Rees, C. E. (2012). "It's just a clash of cultures": emotional talk within medical students' narratives of professionalism dilemmas. *Advances in Health Sciences Education*, **17**(5), 671–701.

Monrouxe, L. V., Chandratilake, M., Gosselin, K., Rees, C. E. & Ho, M. J. (2017). Taiwanese and Sri Lankan students' dimensions and discourses of professionalism. *Medical Education*, **51**(7), 718-731.

Monrouxe, L. V., Rees, C. E. & Hu, W. (2011). Differences in medical students' explicit discourses of professionalism: acting, representing, becoming. *Medical Education*, **45**(6), 585-602.

Monrouxe, L. V., Rees, C. E., Dennis, I. & Wells, S. E. (2015). Professionalism dilemmas, moral distress and the healthcare student: insights from two online UK-wide questionnaire studies. *BMJ Open*, **5**(5), e007518.

Morrow, G., Rothwell, C., Burford, B. & Illing, J. (2013). Cultural dimensions in the transition of overseas medical graduates to the UK workplace. *Medical Teacher*, **35**(10), e1537-e1545.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling, psychology. *Journal of Counseling Psychology*, **52**(2), 250.

Morse, J. M. (2010). "Cherry picking": Writing from thin data [Editorial]. *Qualitative Health Research*, **20**, 3.

Muzio, D. & Kirkpatrick, I. (2011). Introduction: professions and organizations - a conceptual framework. *Current Sociology*, **59**(4), 389–405.

Naqvi, A. S. (1997). Problems of medical education in Pakistan. *Journal of the Pakistan Medical Association*, **47**, 267-269.

Narayana, D. (2004). *Adjustment and health sector reforms: Can there be a way out of low public spending on health in India?* Trivandrum, India: Centre for Development Studies.

Nazim, Z. & Abuzar Wajidi, M. (2016). Updated National Culture of Pakistan-Revisiting Hofstede. *New Horizons* **10**(1), 69-94.

Nesje, K. (2017). Professional commitment: Does it buffer or intensify job demands? *Scandinavian Journal of Psychology*, **58**(2), 185-191.

New South Wales Medical Board (2005). *Code of professional conduct: Duties of a doctor registered with the New South Wales Medical Board*. At: http://www.nswmb.org.au/index.pl?page=59 (Retrieved 16.10.08)

Nie, J. B., Smith, K. L., Cong, Y., Hu, L. & Tucker, J. D. (2015). Medical professionalism in China and the United States: a transcultural interpretation. *Journal of Clinical Ethics*, **26**(1), 48-60.

Nishigori, H., Harrison, R., Busari, J. & Dornan, T. (2014). Bushido and medical professionalism in Japan. *Academic Medicine*, **89**(4), 560.

Nishtar, S. (2010). *Choked Pipes: Reforming Pakistan's Mixed Health System*. Karachi: Oxford University Press.

Nizar, H. & Chagani, P. (2016). Analysis of health care delivery system in Pakistan and Singapore. *International Journal of Nursing Education*, **8**(2), 21-26.

Noordegraaf, M. (2011). Remaking professionals? How associations and professional education connect professionalism and organizations. *Current Sociology*, **59**(4), 465–488.

Noordegraaf, M., Schneider, M. M. E., Van Rensen, E. L. J. & Boselie, J. P. P. E. F. (2016). Cultural complementarity: reshaping professional and organizational logics in developing frontline medical leadership. *Public Management Review*, **18**(8), 1111-1137.

Nunkoosing, K. (2005). The problems with interviews. *Qualitative Health Research*, **15**(5), 698-706.

Nyoni, T. (2019). *A Box-Jenkins ARIMA approach to the population question in Pakistan: A reliable prognosis*. At: https://pdfs.semanticscholar.org/1394/21b6c81ff4877cd96f5813f0a30ab088d44e.pdf (Retrieved 12-02-20)

O'Reilly, C. A., Chatman, J. & Caldwell, D. F. (1991). People and organizational culture: A profile comparison approach to assessing person-organization fit. *Academy of Management Journal*, **34**(3), 487-516.

O'Sullivan, H., van Mook, W., Fewtrell, R. & Wass, V. (2012). Integrating professionalism into the curriculum: AMEE Guide No. 61. *Medical Teacher*, **34**(2), e64-e77.

O'Laoire, S. (1997). An experimental study of the effects of distant, intercessory prayer on self-esteem, anxiety, and depression. *Alternative Therapies in Health and Medicine*, **3**(6), 38–53.

O'Reilly, D. & Reed, M. (2011). The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization. *Organization Studies*, **32**(8), 1079–1101.

Ojuka, D. K., Olenja, J. M., Mwango'mbe, N. J., Yang, E. B. & Macleod, J. B. (2016). Perception of medical professionalism among the surgical community in the University of Nairobi: a mixed method study. *BMC Medical Education*, **16**(1), 101.

Oleson, M. (2004). Exploring the relationship between money attitudes and Maslow's hierarchy of needs. *International Journal of Consumer Studies*, **28**(1), 83-92.

Olie, R. (1995). The 'culture' factor in personnel and organization policies. In A. Harzing & V. R. J. London (Eds.), *International Human Resource Management: An integrated approach* (pp. 124-143). Thousand Oaks: Sage.

Olive, K. E. (1995). Physician religious beliefs and the physician–patient relationship: a study of devout physicians. *Southern Medical Journal,* **88**, 1249-1255.

Owlia, P., Ghanei, M., Mirafzali, S., Siadat, S., Malekifar, S., Esmailzadeh, H. &Saderi, H. (2015). Highlights of the final draft of the National Policy Document for Science, Technology and Innovation in Vaccine Production in Iran. *Vacres*, **2**(1), 1–5.

Paechter, C. (2006). Masculine femininities/feminine masculinities: Power, identities and gender. *Gender and Education*, **18**(3), 253-263.

Page, D. W. (2006). Professionalism and team care in the clinical setting. *Clinical Anatomy*, **19**(5), 468-472.

Pakistan Social and Living Standards Measurement Survey (2018). At: http://www.pbs.gov.pk/content/pakistan-social-and-living-standards-measurement [Retrieved 12-01-19]

Palis, A. G. & Altszul, M. R. (2019). Faculty development for teaching and assessing residents' professionalism. *Annals of Eye Science*, **4,** 30

Pan, H., Norris, J. L., Liang, Y.-S., Li, J.-N. & Ho, M.-J. (2013). Building a professionalism framework for healthcare providers in China: A nominal group technique study. *Medical Teacher*, **35**(10), e1531–e1536.

Papadakis, M. A., Hodgson, C. S., Teherani, A. & Kohatsu, N. D. (2004). Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Academic Medicine*, **79(**3), 244–249.

Park, S. Y., Shon, C., Kwon, O. Y., Yoon, T. Y. & Kwon, I. (2017). A qualitative thematic content analysis of medical students' essays on professionalism. *BMC Medical Education*, **17**(1), 79.

Parks, A. L. & O'Malley, P. G. (2016). From choosing wisely to practicing value - more to the story. *Journal of American Medical Association, Internal Medicine*, **176**(10), 1571-1572.

Parlett, M. & Hamilton, D. (1976). Evaluation as Illumination: a New Approach to the Study of Innovatory Programs. *Curriculum Evaluation Today: Trends and implications, Schools Council Research Series*.

Passi, V., Doug, M., Peile, J. T. & Johnson, N. (2010). Developing medical professionalism in future doctors: a systematic review. *International Journal of Medical Education*, **1**, 19 -29.

Patel, P. J. (2018). Shame and Guilt in India: Declining Social Control and the Role of Education. *South Asia Research*, **38**(3), 287-306.

Pavlica, P. & Barozzi, L. (2003). Medical professionalism in the new millenium: a physician's charter. *La Radiologiamedica*, **105**(4), 263.

Pawlina, W., Hromanik, M. J., Milanese, T. R., Dierkhising, R., Viggiano, T. R. & Carmichael, S. W. (2006). Leadership and professionalism curriculum in the gross anatomy course. *Annals of the Academy of Medicine Singapore*, **35**(9), 609.

Peters, M. D., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D. & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *International Journal of Evidence-Based Healthcare*, **13**(3), 141-146.

Phillips, S. P. & Clarke, M. (2012). More than an education: the hidden curriculum, professional attitudes and career choice. *Medical Education*, **46**(9), 887–893.

Phillips, S. P. & Dalgarno, N. (2017). Professionalism, professionalization, expertise and compassion: a qualitative study of medical residents. *BMC Medical Education*, **17**(1), 21.

Piller, I. (2011) *Intercultural Communication: A Critical Introduction.* Edinburgh: Edinburgh University Press

PMDC (2002). *Code of Ethics of practice for Medical and Dental Colleges.* Islamabad: Pakistan Medical and Dental Council

PMDC (2009). *The Statutory Regulatory & Registration Authority for Medical & Dental Education and Practitioners of Pakistan*. Islamabad, Pakistan. Pakistan Medical & Dental Council

PMDC (2018). *The Gazette of Pakistan* At: http://www.pmdc.org.pk/Portals/0/admission%20housejob%20regulations.pdf [Retrieved 12-01-2020]

Pope, C., Ziebland, S. & Mays, N. (2000). Qualitative research in health care: analysing qualitative data. *British Medical Journal* **320**(7227), 114.

Popoiu, M. C., Grosseck, G. & Holotescu, C. (2012). What do we know about the use of social media in medical education? *Procedia-Social and Behavioral Sciences*, **46**, 2262-2266.

Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, **2**(4), 281-307.

Preston, R., Larkins, S., Taylor, J. & Judd, J. (2016). From personal to global: understandings of social accountability from stakeholders at four medical schools. *Medical Teacher*, **38**(10), 987-994.

Puschel, K., Repetto, P., Bernales, M., Barros, J., Perez, I. & Snell, L. (2017). "In our own words": Defining medical professionalism from a Latin American perspective. *Education for Health*, **30**(1), 11.

Qu, B., Zhao, Y. H. & Sun, B. Z. (2012). Assessment of resident physicians in professionalism, interpersonal and communication skills: a multisource feedback. *International Journal of Medical Sciences*, **9**(3), 228.

Rashid, A., Irum, A., Malik, I. A., Ashraf, A., Rongqiong, L., Liu, G. ... & Yousaf, B. (2018). Ecological footprint of Rawalpindi; Pakistan's first footprint analysis from urbanization perspective. *Journal of Cleaner Production*, **170**, 362-368.

Rathore, A.H. (2013). *Postgraduate Medical Education in Pakistan (1947-2012).* At: http://www.pulsepakistan.com/index.php/main-news-nov-1-12/104-postgraduate-medical-education-in-pakistan-1947-to-2012 (Retrieved January 5, 2013)

Reay, T. & Hinings, C. R. (2009). Managing the rivalry of competing institutional logics. *Organization Studies*, **30**(6), 629-652.

Rehman, K., Rehman, Z.-U., Saif, N., Khan, A. S., Nawaz, A. & Rehman, S. (2013). Impacts of job satisfaction on organizational commitment: a theoretical model for academicians in HEI of developing countries like Pakistan. *International Journal of Academic Research in Accounting, Finance and Management Sciences*, **3**(1), 80–89.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, **18** (1), 20-23.

Relman, A. S. (2007). Medical professionalism in a commercialized health care market. *Journal of the American Medical Association*, **298**(22), 2668-2670.

Rennie, S. C. & Crosby, J. R. (2002). Students' perceptions of whistle-blowing: implications for self-regulation. A questionnaire and focus group survey. *Medical Education*, **36**(2), 173-179.

Rinne, T., Steel, G. D. & Fairweather, J. (2013). The role of Hofstede's individualism in national-level creativity. *Creativity Research Journal,* **25**(1), 129–136.

Roberson, P. (2016). *The role of spirituality in the wellbeing of community health care workers at Temba Community Development Services* (PhD Thesis). University of South Africa.

Robertson, D. W. (1996). Ethical theory, ethnography, and differences between doctors and nurses in approaches to patient care. *Journal of Medical Ethics*, **22**(5), 292-299.

Rodham, K., Fox, F. & Doran, N. (2015). Exploring analytical trustworthiness and the process of reaching consensus in interpretative phenomenological analysis: Lost in transcription. *International Journal of Social Research Methodology*, **18**(1), 59-71.

Rodulson, V., Marshall, R. & Bleakley, A. (2015). Whistleblowing in medicine and in Homer's Iliad. *Medical Humanities*, **41**(2), 95-101.

Roff, S., Druce, M., Livingston, K., Roberts, C. M. & Stephenson, A. (2015). Mapping norms of academic integrity as an aid to proactive regulation. *Journal of Medical Regulation*, **101**(3), 24-31

Roland, M., Rao, S. R., Sibbald, B., Hann, M., Harrison, S., Walter, A. & Campbell, E. G. (2011). Professional values and reported behaviours of doctors in the USA and UK: a quantitative survey. *BMJ Quality & Safety*, **20**(6), 515-521.

Rosenstein, A. H. (2015). Physician disruptive behaviors: Five-year progress report. *World Journal of Clinical Cases*, **3**(11), 930.

Rothman, D. J., Blumenthal, D. & Thibault, G. E. (2020). Medical professionalism in an organizational age: challenges and opportunities: Strategies for physicians to address the key responsibilities of medical professionalism in an era of profound change in the structure of medical care. *Health Affairs*, **39**(1), 108-114.

Rothwell, C., Morrow, G., Burford, B. & Illing, J. (2013). Ways in which healthcare organisations can support overseas-qualified doctors in the UK. *International Journal of Medical Education*. **4**, 75-82.

Rougas, S., Gentilesco, B., Green, E. & Flores, L. (2015). Twelve tips for addressing medical student and resident physician lapses in professionalism. *Medical Teacher*, **37**(10), 901–907.

Rowland, P. & Kuper, A. (2018). Beyond vulnerability: how the dual role of patient-health care provider can inform health professions education. *Advances in Health Sciences Education*, **23**(1), 115–131.

Rowland, P. A., Coe, N. P., Burchard, K. W. & Pricolo, V. E. (2005). Factors affecting the professional image of physicians. *Current Surgery*, **62**(2), 214-219.

Royal College of Physicians and Surgeons of Canada. (2000). CanMEDS 2000: Extract from the CanMEDS 2000 Project Societal Needs Working Group Report. *Medical Teacher*, **22**, 549-554.

Royal College of Physicians of London (2005). *Doctors in Society: Medical Professionalism in a Changing World*. Technical Supplement to a Report of a Working Party of the Royal College of Physicians of London, December 2005: Royal College of Physicians.

Salloch, S. (2017). Who's afraid of EBM? Medical professionalism from the perspective of evidence-based medicine. *Medicine, Health Care and Philosophy*, **20**(1), 61–66.

San-Martín, M., Delgado-Bolton, R. & Vivanco, L. (2017). Professionalism and Occupational Well-Being: Similarities and Differences Among Latin American Health Professionals. *Frontiers in Psychology*, **8**, 63.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*. **8**, 27-37.

Sattar, K. & Roff, S. (2016). Comparison of recommended sanctions for lapses in professionalism of undergraduate medical students in a Saudi Arabian and a Scottish medical school. *Medical Teacher*, **38**(12), 1262-1266.

Sattar, K., Roff, S. & Meo, S. A. (2016a). Your professionalism is not my professionalism: congruence and variance in the views of medical students and faculty about professionalism. *BMC Medical Education*, **16**(1), 285.

Sattar, K., Roff, S. & Meo, S. A. (2016b). Similarities and variances in perception of professionalism among Saudi and Egyptian medical students. *Pakistan Journal of Medical Sciences*, **32**(6), 1390.

Scheele, F., Teunissen, P., Luijk, S. V., Heineman, E., Fluit, L., Mulder, H., … Hummel, T. (2008). Introducing competency-based postgraduate medical education in the Netherlands. *Medical Teacher*, **30**(3), 248–253.

Schlabach, G. A. (2017). Professional values: Cultivating the social contract with the seeds of professionalism. *International Journal of Athletic Therapy and Training*, **22**(1), 11-18.

Schmeiser, M. (2006). SoziologischeAnsätze der Analyse von Professionen, der Professionalisierung und des professionellenHandelns. *Soziale Welt*, **57**(3), 295–318.

Schmidt, K., Rees, C., Greenfield, S., Wearn, A. & Dennis, I. (2004). Identifying medical students' attitudes towards 'holism'. *Focus on Alternative and Complementary Therapies*, **9**, 47-48.

Schmitt, M., Blue, A., Aschenbrener, C. A. & Viggiano, T. R. (2011). Core competencies for interprofessional collaborative practice: reforming health care by transforming health professionals' education. *Academic Medicine* **86**(11), 1351-1351.

Schoenberger, N. E., Matheis, R. J., Shiflett, S. C. & Cotter, A. C. (2002). Opinions and practices of medical rehabilitation professionals regarding prayer and meditation. *The Journal of Alternative & Complementary Medicine*, **8**(1), 59–69.

Schuwirth, L. W. & Van der Vleuten, C. P. (2011). Programmatic assessment: from assessment of learning to assessment for learning. *Medical Teacher*, **33**(6), 478-485.

Schwartz, S. H. (1999). A theory of cultural values and some implications for work. *Applied Psychology*, **48**(1), 23-47.

Senders, J. W. (2018). Medical devices, medical errors, and medical accidents. In M.S. Bogner (Ed.), *Human Error in Medicine* (pp. 159-177). Hillsdale, NJ: CRC Press.

Sethi, A. & Javaid, A. (2017). Accreditation System and Standards for Medical Education in Pakistan: It's time we raise the bar. *Pakistan Journal of Medical Sciences,* **33**(6), 1299.

Seys, D., Scott, S., Wu, A., Van Gerven, E., Vleugels, A., Euwema, M., … Vanhaecht, K. (2013). Supporting involved health care professionals (second victims) following an adverse health event: a literature review. *International Journal of Nursing Studies*, **50**(5), 678–687.

Shahid, S. & Zain, Z. (2018). *Propensity of Demographic Factors on Affective Organizational Commitment: An Empirical Study*. At: https://meritresearchjournals.org/bm/content/2018/January/Shahid%20and%20Zain.pdf. [Retrieved 10-01-1-2019]

Shaikh A., Naqvi S.H., Sheikh, K., Naqvi S.H. & Bandukda M.Y. (2012). Physician migration at its roots: A study on the factors contributing towards a career choice abroad among students at a medical school in Pakistan. *Global Health* **15**(8);43.

Shakour, M., Yamani, N. & Yousefi, A. (2016). Preparations before faculty development programs for medical professionalism for clinical teachers. *Acta Medica Mediterranea*, **32**, 1483-1491.

Shapiro, J., Nixon, L. L., Wear, S. E. & Doukas, D. J. (2015). Medical professionalism: what the study of literature can contribute to the conversation. *Philosophy, Ethics, and Humanities in Medicine*, **10**(1), 10.

Shaw, M. K., Rees, C. E., Andersen, N. B., Black, L. F. & Monrouxe, L. V. (2018). Professionalism lapses and hierarchies: A qualitative analysis of medical students' narrated acts of resistance. *Social Science & Medicine*, **219**, 45-53.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, **7**(3), 233-243.

Shelton, C. L., Smith, A. F. & Mort, M. (2014). Opening up the black box: an introduction to qualitative research methods in anaesthesia. *Anaesthesia*, **69**(3), 270-280.

Shrivasta, S. R., Shrivasta, P. S. & Ramasamy, J. (2014). Effective feedback: An indispensable tool for improvement in quality of medical education. *Journal of Pedagogic Development*, **4**(1), 12- 20.

Shukr, I. (2014). Defining medical professionalism and academic integrity, a function of medical councils and medical colleges. *Pakistan Armed Forces Medical Journal*, **64**(2), 181-4.

Shultz, S. M. (2011). Quest for professionalism: a biography of the North American Medical and Surgical Journal (1826–31). *Journal of Medical Biography*, **19**(3), 132-137.

Siddiqui, F. G. & Shaikh, N. A. (2014). Challenges and Issues in Medical Education in Pakistan. *Journal of Liaquat University Medical and Health Sciences*, **13**(3), 91-2.

Simpkin, A. L. & Walesby, K. E. (2017). Training tomorrow's doctors. *Future Hospital Journal*, **4**(1), 56-60.

Singh, T., de Grave, W., Ganjiwale, J., Supe, A., Burdick, W. P. & van der Vleuten, C. (2013). Impact of a fellowship program for faculty development on the self-efficacy beliefs of health professions teachers: a longitudinal study. *Medical Teacher*, **35**(5), 359-364.

Skeff, K. M., Stratos, G. A., Mygdal, W., DeWitt, T. A., Manfred, L., Quirk, M., ... & Bland, C. J. (1997). Faculty development: a resource for clinical teachers. *Journal of General Internal Medicine*, **12**(Suppl 2), S56.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, **1**(1), 39-54.

Smith, J. A. & Osborn, M. (2004). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Doing Social Psychology Research* (pp. 229-254). London: Sage.

Smith, P., Dugan, S. & Trompenaars, F. (1996). National culture and the values of organizational employees - a dimensional analysis across 43 nations. *Journal of Cross-Cultural Psychology,* **27**(2), 231–64.

Smith, R. (2006). Medical professionalism: out with the old and in with the new. *Journal of the Royal Society of Medicine*, **99**, 48–50.

Smits, P. B.A., Buisonjé, C.D., Verbeek, J. H., van Dijk, F. J., Metz, J. C. & Ten Cate, O. J. (2003). Problem-based learning versus lecture-based learning in postgraduate medical education. *Scandinavian Journal of Work, Environment & Health,* **29**(4), 280-287.

Smits, P.B.A., Verbeek, J.H. and Buisonje, C.D. (2002). Problem based learning in continuing medical education: A review of controlled evaluation studies. *British Medical Journal* **324**, 153–156.

Soares, A. M., Farhangmehr, M. & Shoham, A. (2007). Hofstede's dimensions of culture in international marketing studies. *Journal of Business Research*, **60**(3), 277-284.

Solanki, A. & Kashyap, S. (2014). Medical education in India: Current challenges and the way forward. *Medical Teacher*, **36**(12), 1027-1031.

Søndergaard, M. (1994). Research note: Hofstede's consequences: a study of reviews, citations and replications. *Organization Studies*, **15**(3), 447-456.

Sood, R. & Adkoli, B. V. (2000). Medical education in India - problems and prospects. *Journal of Indian Academic Clinical Medicine*, **1**(3), 210-212.

Spence, J. T. (1985). Achievement American style: The rewards and costs of individualism. *American Psychologist*, **40**(12), 1285–1295.

St. Pierre, E. A. (2006). Scientifically based research in education: Epistemology and ethics. *Adult Education Quarterly*, **56(**4), 239-266.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.

Stark, R., Korenstein, D. & Karani, R. (2008). Impact of a 360-degree professionalism assessment on faculty comfort and skills in feedback delivery. *Journal of General Internal Medicine*, **23(**7), 969–972.

Starr, P. (2008). *The social transformation of American medicine: The rise of a sovereign profession and the making of a vast industry*. New York: Basic Books.

Steenkamp J. (2001). The role of national culture in international marketing research. *International Marketing Review* **18**(1):30–44.

Steinert, Y., Cruess, S., Cruess, R. & Snell, L. (2005). Faculty development for teaching and evaluating professionalism: from programme design to curriculum change. *Medical Education*, **39**(2), 127-136.

Stern, D. T. & Papadakis, M. (2006). The developing physician - becoming a professional. *New England Journal of Medicine*, **355**(17), 1794–1799.

Stern, D. T., Frohna, A. Z. & Gruppen, L. D. (2005). The prediction of professional behaviour. *Medical Education*, **39**(1), 75-82.

Strauss, A. & Corbin, J. (1998). *Basics of Qualitative Research Techniques*. Thousand Oaks, CA: Sage Publications.

Struckmann, V., Panteli, D., Legido-Quigley, H., Risso-Gill, I., McKee, M. & Busse, R. (2015). Deciding when physicians are unfit to practise: an analysis of responsibilities, policy and practice in 11 European Union member states. *Clinical Medicine*, **15**(4), 319-324.

Subedi, B. (2006). Theorizing a 'halfie' researcher's identity in transnational fieldwork. *International Journal of Qualitative Studies in Education*, **19**(5), 573-593.

Sullivan, K. M. (1992). Religion and liberal democracy. *University of Chicago Law Review*, **59**, 195.

Sullivan, W. (2005). *Work and Integrity: the Crisis and Promise of Professionalism in America*. San Francisco, CA: Jossey-Bass

Svensson, L. G. (2006). New professionalism, trust and competence: Some conceptual remarks and empirical data. *Current Sociology*, **54**(4), 579–593.

Swick, H. M. (2000). Toward a normative definition of medical professionalism. *Academic Medicine*, **75**(6), 612-616.

Swick, H. M., Szenas, P., Danoff, D. & Whitcomb, M. E. (1999). Teaching professionalism in undergraduate medical education. *Journal of American Medical Association*, **282**(9), 830-832.

Swing, S. R. (2007). The ACGME outcome project: retrospective and prospective. *Medical Teacher*, **29**(7), 648-654.

Talati, J.J. & Pappas, G. (2006). Migration, Medical Education, and Healthcare: A View from Pakistan. *Academic Medicine* **81**(Suppl12): S55–62.

Tallis, R. C. (2006). Doctors in society: medical professionalism in a changing world. *Clinical Medicine*, **6**(1), 7-12.

Tellis, W. (1997). Application of a case study methodology. *The Qualitative Report*, **3**(3), 1-19.

Tennhoff, W., Nentwich, J. C. & Vogt, F. (2015). Doing gender and professionalism: Exploring the intersectionalities of gender and professionalization in early childhood education. *European Early Childhood Education Research Journal*, **23**(3), 340–350.

Terhorst, L., Leach, M., Bussières, A., Evans, R. & Schneider, M. J. (2016). Evaluating the psychometric properties of the evidence-based practice attitude and utilization survey. *The Journal of Alternative and Complementary Medicine*, **22**(4), 328–335.

Thistlethwaite, J. & Spencer, J. (2016). *Professionalism in medicine*. London: CRC Press.

Thomas, P. & Hewitt, J. (2011). Managerial organization and professional autonomy: a discourse-based conceptualization. *Organization Studies*, **32**(10), 1373–1393.

Thomasma, D. C. & Kissell, J. L. (Eds.). (2000). *The health care professional as friend and healer: Building on the work of Edmund D. Pellegrino*. Washington, DC: Georgetown University Press.

Tilburt, J. C., Wynia, M. K., Sheeler, R. D., Thorsteinsdottir, B., James, K. M., Egginton, J. S., ... & Goold, S. D. (2013). Views of US physicians about controlling health care costs. *Journal of the American Medical Association,* **310**(4), 380-389.

Trainor, A. A. & Graue, E. (2014). Evaluating rigor in qualitative methodology and research dissemination. *Remedial and Special Education*, **35**(5), 267-274.

Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of Personality*, **69**(6), 907-924.

Tsai, T. C., Lin, C. H., Harasym, P. H. & Violato, C. (2007). Students' perception on medical professionalism: the psychometric perspective. *Medical Teacher*, **29**(2-3), 128-134.

Tschannen-Moran, M. (2009). Fostering teacher professionalism in schools: The role of leadership orientation and trust. *Educational Administration Quarterly*, **45**(2), 217-247.

Tsen, L., Shapiro, J. & Ashley, S. (2017). Conflict Resolution. In M. L. Donlin (Ed.), *Surgical Quality Improvement* (pp. 75–83). New York, NY: Springer.

Tufford, L. & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, **11**(1), 80-96.

Turabian, J. L., Minier-Rodriguez, L. E., Moreno-Ruiz, S., Rodriguez-Almonte, F. E. & Cucho-Jove, R. (2017). Differences in verbal behaviour style in interviews of patient females with patient's companion (triads) and without patient's companion (dyads) in family medicine. *Journal of General Practice*, **5**(313), 2.

Turabián, J. L., Minier-Rodriguez, L. E., Rodriguez-Almonte, F. E. & Cucho-Jove, R. (2017). The social and health gender differences in patients companion in the family medicine consultation. *Current Research: Integrative Medicine*, **2**(1), 45-49.

Tylor, E. (2004). The evolution of culture. In D. J. Moore (Ed.), *Visions of Culture: An Introduction to Anthropological Theories and Theorists* (5th Ed.). Maryland: Rowman and Littlefield.

Veatch, R. M. (2000). Internal and external sources of morality for medicine. In D. Thomasma & J. L. Kissell (Eds.), *The Healthcare Professional as Friend and Healer* (pp. 75-86). Washington, D. C.: Georgetown University Press.

Veatch, R. M. (2001). The impossibility of a morality internal to medicine. *Journal of Medicine and Philosophy*, **26(**6), 621-642.

Veloski, J. & Hojat, M. (2006). Measuring specific elements of professionalism: empathy, teamwork, and lifelong learning. In: *Measuring Medical Professionalism* (pp.117-145). Oxford: Oxford University Press.

Vogel, D., Meyer, M. & Harendza, S. (2018). Verbal and non-verbal communication skills including empathy during history taking of undergraduate medical students. *BMC Medical Education*, **18**(1), 157.

Wagner, P., Hendrich, J., Moseley, G. & Hudson, V. (2007). Defining medical professionalism: a qualitative study. *Medical Education*, **41**(3), 288-294.

Wald, H. S., McFarland, J. & Markovina, I. (2019). Medical humanities in medical education and practice. *Medical Teacher*, **41**(5), 492-496.

Walsh, C. & Abelson, H. T. (2008). Medical professionalism: Crossing a generational divide. *Perspectives in Biology and Medicine*, **51**(4), 554-564.

Waring, J. (2007). Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. *Sociology of Health & Illness*, **29**(2), 163-179.

Wear, D. & Castellani, B. (2000). The development of professionalism: curriculum matters. *Academic Medicine*, **75**(6), 602-611.

Wear, D. & Kuczewski, M. G. (2004). The professionalism movement: Can we pause? *American Journal of Bioethics*, **4**(2), 1-10.

Wearn, A., Wilson, H., Hawken, S. J., Child, S. & Mitchell, C. J. (2010). In search of professionalism: implications for medical education. *New Zealand Medical Journal*, **12**(3), 13-14.

Welch, J. S. (2003). Ritual in western medicine and its role in placebo healing. *Journal of Religion and Health*, **42**(1), 21-33.

West, C. P. & Shanafelt, T. D. (2007). The influence of personal and environmental factors on professionalism in medical education. *BMC Medical Education*, **7**(1), 29.

White, P. (2004). Medical professionalism and continuing professional development for medical specialists. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, **44**(3), 186-190.

Wilson, I., Cowin, L. S., Johnson, M. & Young, H. (2013). Professional identity in medical students: pedagogical challenges to medical education. *Teaching and Learning in Medicine*, **25**(4), 369-373.

Wood, P. & Arcus, K. (2011). Poverty, philanthropy, and professionalism: The establishment of a district nursing service in Wellington, New Zealand, 1903. *Health and History*, **13(**1), 44–64.

Woodruff, J. N., Angelos, P. &Valaitis, S. (2008). Medical professionalism: one size fits all? *Perspectives in Biology and Medicine*, **51**(4), 525-534.

World Health Organization. (2016). *World health statistics 2016: monitoring health for the SDGs sustainable development goals*. World Health Organization.

World Population Statistics (2013). *Pakistan Population*. Retrieved from http://www.worldpopulationstatistics.com/pakistan-population2013/ [12-07-15]

Wynia, M. K., Papadakis, M. A., Sullivan, W. M. & Hafferty, F. W. (2014). More than a list of values and desired behaviors: a foundational understanding of medical professionalism. *Academic Medicine*, **89**(5), 712-714.

Yamani, N., Shakour, M., & Yousefi, A. (2016). The expected results of faculty development programs in medical professionalism from the viewpoint of medical education experts. *Journal of Research in Medical Sciences : The Official Journal of Isfahan University of Medical Sciences*, **21**(11).

Yardley, L. (2008). Demonstrating validity in qualitative psychology. *Qualitative Psychology: A Practical Guide to Research Methods*, **2**, 235-251.

Yazan, B. (2015). Three approaches to case study methods in education: Yin, Merriam, and Stake. *The Qualitative Report*, **20**(2), 134-152.

Yin, R. (2002) *Case Study Research: Design and Methods*. Thousand Oaks: Sage.

Yoo, B., Donthu, N. & Lenartowicz, T. (2011). Measuring Hofstede's five dimensions of cultural values at the individual level: Development and validation of CVSCALE. *Journal of International Consumer Marketing*, **23**(3-4), 193-210.

Youssef, V. C., Peters, D. & Youssef, F. F. (2016). “It's All About How You Carry Yourself About”: How Medical Students Conceptualize Professionalism in Trinidad & Tobago. *Teaching and Learning in Medicine*, **28**(4), 367-374.

Zafiropoulos, G. (2017). Definition of professionalism by different groups of health care students. *Educational Research and Reviews*, **12**(7), 380-386.

Zajda, J. (2015). Overview and Introduction. In J. Zajda (Ed.), *Second International Handbook on Globalisation, Education and Policy Research* (pp. 1–13). Dordrecht: Springer Netherlands.

Zavestovskaya, I. (2018). Alliance of translational medicine: On the way to get R&D, clinical affairs, biopharma & business. *Meta Gene*, **17**(S1), S2.

Zerfass, A. & Huck, S. (2007). Innovation, communication, and leadership: New developments in strategic communication. *International Journal of Strategic Communication*, **1**(2), 107-122.

APPENDIX I Search Terms

In order to further narrow or broaden the search, “AND”, “OR”, and “NOT” Boolean operators were used. The following list of key words was used in the data search:

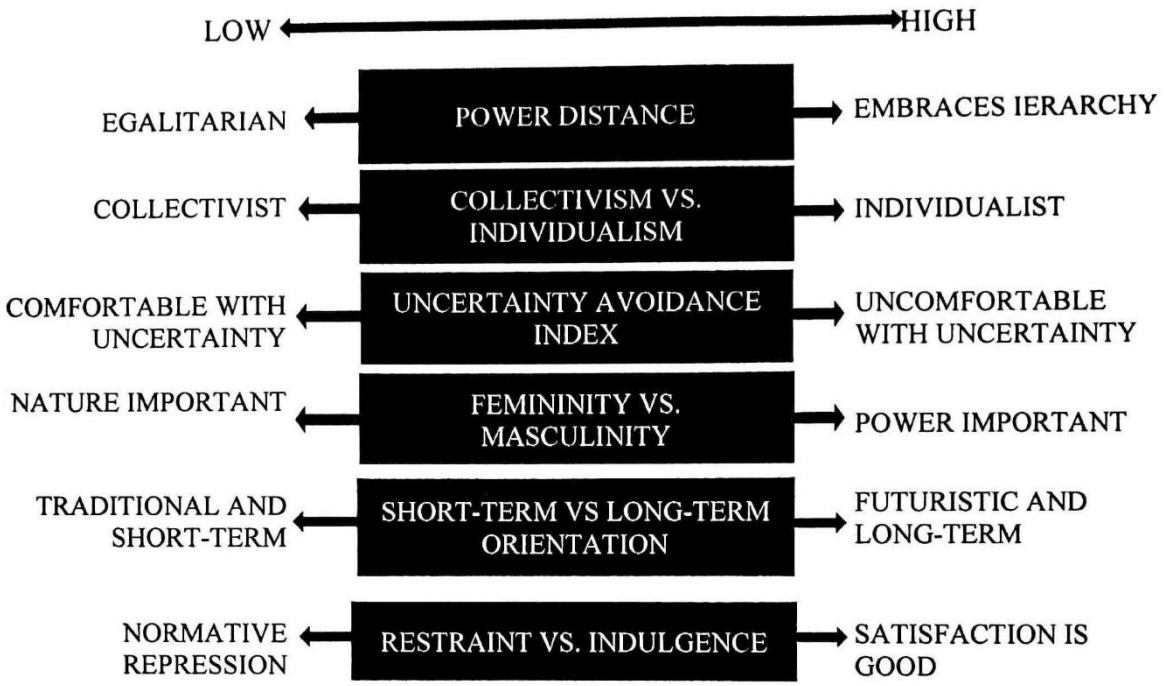
1. Professionalism
2. Medical Education
3. Medical Professionalism
4. Professional Behaviour
5. Perception of Professionalism
6. Self-Assessing Professionalism
7. Perceptions of Medical Professionalism
8. Understanding of Medical Professionalism
9. Medical Professionalism Understanding
10. Medical Professionalism Perceptions
11. Defining Medical Professionalism
12. Medical Professionalism Definitions
13. Medical Professionalism in Regional Contexts
14. Contexts of Medical Professionalism
15. Contextual Relevance of Medical Professionalism
16. Conceptions of Professionalism
17. Latest Trends in Medical Professionalism
18. Role as Medical Professional
19. Medical Professional Role
20. Rethinking Medical Professionalism
21. Valuating Medical Professionalism
22. Requirements of Medical Professionalism
23. Challenges of Medical Professionalism
24. Medical Professionalism Challenges
25. Medical Professionalism Identity
26. Identity of Medical Professionalism
27. Identifying Medical Professionalism
28. Future of Medical Professionalism
29. Medical Professionalism in Future
30. Duties of Medical Professional
31. Adoption of Medical Professionalism
32. Competencies in Medical Professionalism
33. Learning Environment & Medical Professionalism
34. Trends in Medical Professionalism
35. Medical Professionalism & Trends
36. Professionalism in Pakistan
37. Medical Professionalism in Pakistan
38. Professional Essence
39. Professional Practice
40. Communication Skills and Professionalism
41. Contextual Professionalism
42. Professionalism & Development
43. Knowledge & Professionalism

44. Assessment and Professionalism
45. Professionalism & Phronesis
46. Dimensions of Professionalism
47. Professional Organization
48. Teaching Medical Professionalism
49. Believing in Professionalism
50. Standards, Professional Practice
51. Tasks and Medical Professionalism
52. Learning in Context & Medical Professionalism
53. Unprofessional Behaviour and Medical Professionalism
54. Attitudes in Medical Professionalism
55. Professional Behaviour & Medical Professionalism
56. Definition of Profession
57. Elements of Medical Professionalism
58. Educational Environment & Medical Professionalism
59. The Practice Based Learning & Medical Professionalism
60. Professionalism Education
61. Professional Identity Formation
62. Standardization of Professionalism
63. Views on Professionalism
64. Views of Medical Professionalism
65. Cultural Competence and Medical Professionalism
66. Medical Ethics
67. Definition of Cultural Drivers
68. Impact of Medical Professionalism
69. Authentic Professionalism
70. Culture Change & Professionalism
71. Professionalism & Humanism
72. Integrity & Professionalism
73. Professionalism Climate
74. Professing Professionalism
75. Assessment of Ethics & Professionalism
76. Managerialism & Medical Professionalism
77. Learning in Medical Professionalism
78. Cultural Prospective & Professionalism
79. Fostering Professionalism
80. Debate in Medical Professionalism
81. Performance &Medical Professionalism
82. Analysis of Medical Professionalism
83. Professionalism & Healthcare Delivery System
84. Reflexes in Professionalism
85. Attitudes & Behaviours in Medical Professionalism
86. Professionalism & Desirable Behaviour
87. Undesirable Behaviours in Medical Professionalism
88. Understanding Healthcare System through Professionalism
89. Doctor Patient Relationship
90. Professionalism in Medical Practice
91. Medical Ethics & the Professional
92. Medical Humanities

93. Gender & Professionalism
94. Skills & Attitudes in Medical Professional
95. Moral Compass of Healthcare Provider
96. Values and Behaviour in Medical Practice
97. Cultural Prospective of Doctor Patient Relationship
98. Standards of Care in Medical Practice
99. Healthcare Ethics

Appendix II

Hofstede's Cultural Dimensions



Appendix III

List of Govt. Sector Medical & Dental Colleges

1. King Edward Medical University
2. Fatima Jinnah Medical University Lahore (**only for Girls**)
3. Nishtar Medical College
4. Quaid-e-Azam Medical College
5. Punjab Medical College
6. Rawalpindi Medical University, Rawalpindi
7. Allama Iqbal Medical College
8. Services Institute of Medical Sciences
9. Sheikh Zayed Medical College
10. Sargodha Medical College, Uni of Sargodha
11. Nawaz Sharif Medical College
12. Shaikh Khalifa Bin Zayed Al Nahyan Medical & Dental College
13. Gujranwala Medical College
14. Sahiwal Medical College
15. Khawaja Muhammad Safdar Medical College, Sialkot
16. Dera Ghazi Khan Medical College
17. Ameer- ud- Din Medical College

List of Dental Institutes

18. De'Montmorency College of Dentistry (BDS)
19. Nishtar Institute of Dentistry (BDS)
20. Dental Section- PMC-FSd (BDS)

List of Private Sector Medical & Dental Colleges of Punjab

21. Foundation University Medical College, Islamabad
22. FMH College of Medicine & Dentistry, Lahore
23. Islamic International Medical College, Islamabad
24. Lahore Medical & Dental College, Lahore
25. University Medical & Dental College, Faisalabad
26. University College of Medicine & Dentistry Lahore
27. Independent Medical College, Lahore
28. Sharif Medical & Dental College, Lahore
29. Continental Medical College, Lahore
30. Akhtar Saeed Medical & Dental College, Lahore
31. Central Park Medical College, Lahore
32. Multan Medical & Dental College, Multan
33. Shalamar Medical & Dental College, Lahore
34. Rashid Latif Medical College, Lahore
35. Islam Medical College, Sialkot
36. Azra Naheed Medical College, Lahore
37. Al-Nafees Medical College
38. Rai Medical College, Sarghoda
39. Aziz Fatima Medical & Dental College

40. Sialkot Medical College, Sialkot
41. Margalla College of Dentistry
42. Islam Dental College, Sialkot
43. Foundation University College of Dentistry, Faisalabad
44. Sahara Medical College
45. Bakhtawar Amin Medical & Dental College, Multan
46. Pak Red Crescent Medical & Dental College
47. Avicenna Medical College Lahore
48. Faryal Dental College
49. Al-Aleem Medical College Gulab Devi Medical Complex Lahore

Appendix IV

Map of Punjab Province of Pakistan

APPENDIX - V

SAMPLE EMAIL TO INSTITUTIONAL HEADS

Subject: Focus Group Discussions for Research Titled "**Understanding the stakeholders' perspectives on professionalism in healthcare: a cross-cultural analysis"**

Dear Sir,

The Research project titled "Understanding the stakeholders' perspectives on professionalism in healthcare: a cross-cultural analysis" is a Higher Education Commission Pakistan funded project won by the undersigned through open competition. The grant has been made available from the 'Strengthening of Basic Medical Sciences' project of University of Health Sciences Lahore. Successful completion of the research and defence of the thesis may lead to the award of a PhD degree from the University of Liverpool, UK.

The purpose for conducting this research is to understand what medical professionalism means to various groups of people individually and collectively. These groups include nurses, allied health sciences students, medical students, doctors, policy makers and patients. At this time I am requesting you to facilitate my discussion only to discuss this with the doctors and medical students. I may request you to organize focus group discussions with other groups at a later date.

Understanding what meanings these stakeholders develop and also how they develop these meanings will help in educational policy-making within the health professions not just in Punjab but across the globe. Moreover, the findings from this study will go on to inform future researchers as they endeavour to undertake further research in this area.

The research questions it needs to answer are:

1. What are the perceptions of doctors, nurses, students, administrators and policymakers in the Punjab, Pakistan, regarding medical professionalism?
2. How does this sense-making of medical professionalism amongst stakeholders in the Punjab, Pakistan, compare with the evidence available in the international literature regarding sense-making by stakeholders in other regions of the world?
3. How do the perceptions and understanding of medical professionalism differ amongst various stakeholders within the healthcare delivery system of the Punjab, Pakistan?

For the purpose of data collection, you are kindly requested to forward this information to your students and faculty, and seek volunteers from amongst them at your earliest convenience. The volunteers are requested to fill in the following form and return through your office to the undersigned:

Faculty

Full name: _____ Age: _____ Sex: _____

Department: _____ Years of service in the institution: _____

Designation:_____

Reason for participating: _____

Student

Full name: _____ Age: _____ Sex: _____

Year of Studies: _____

Reason for participating:_____

The undersigned shall visit your institution on 30th April 2015, there shall be two rounds of discussions, one with faculty and the other with the students. Each round may take up to 2 hours. The faculty focus group discussion shall be carried out first from 9am onwards followed by a focus group discussion with students from 1pm onwards. I request that I be allowed to conduct their discussions in your conference hall. Please have stationery and mineral water available in the conference hall.

Please call the faculty volunteers at 8am and student volunteers at 12pm. I shall personally interact with the volunteers and select not more than fifteen volunteers from each group for discussion. I shall explain the research, its protocol, their rights and present to them the consent form for signing. They will have full autonomy to leave the research group at any point during the study. I shall bring my own recording devices for recording the conversation and shall be assisted by two assistants from my office. Please note that this is not UHS official business and also that the volunteers shall not be paid any honorarium. Strict confidentiality relating to the name of institution and identity of the participants shall be maintained. Ethical approval for the study has been obtained and is attached with this email.

The findings of the study shall have no reflection on institution, its administration and the participants in any way.

I request your full cooperation for the sake of promoting medical education in the country.

Yours sincerely,
Prof Dr. Junaid Sarfraz Khan
Pro Vice Chancellor
University Of Health Sciences, Lahore
Tele: 0092324430217

APPENDIX VI

Total Participants

Participants (code) No. of FGDs	Females (F)	Males (M)	Participants			Total
			North Punjab	Central Punjab	South Punjab	
Doctors (FC) 12	73	112	36	91	58	185
MBBS Students (MS) 10	80	66	18	82	46	146
Nurses (NR) 6	48	10	24	s17	17	58
Policymakers (PM) 2	13	17	10	10	10	30
Patients (PT) 4	35	21	12	32	12	56
Allied Health Sciences students (AH) 4	32	23	0	42	13	55
Grand Total 38	281	249	100	274	156	530

APPENDIX VII

Focus Group Discussion Questions

1: Questions for Faculty& Health Policymakers

1.	What do you understand by the term 'Medical Professionalism'?
2.	Can we differentiate professionalism from what we are?
3.	Who defines that a doctor is professional or otherwise?
4.	How can you develop right kind of attitude?
5.	From where attitude towards working in clinical practice comes from?
6.	What is the influence of Materialism on professionalism?
7.	What sort of influence does Materialism have on professionalism?
8.	Is there any influence of religion on professionalism?
9.	Who decides what is expected from the doctor?
10.	What sort of behavior is expected from doctors, by the communities he/she is working in?
11.	Attitude towards our working in clinical practice, where do these come from?
12.	Do expectations of the society vary depending on society to society or place to place?
13.	Is there something else that society, people, doctor can do to ensure that professionalism is practiced?
14.	Does socio-economic status threaten professionalism?
15.	Do you agree with the statement that if the society is educated and it is aware of its rights and responsibilities, the doctors will be behaving more professionally?
16.	Does society's level of education affect behavior and professional practice of doctors?
17.	Is there any role of educating the society regarding their rights, their responsibilities?
18.	Are religion and culture separate or the same things?
19.	Does religion influence our code of ethics?
20.	Is there anything that can standardize or improve behavior of the doctors?
21.	Do peers and role models affect professional behavior?
22.	Does society expect that a doctor with high status is a good doctor?

23.	How does role model affect a person's professional behavior?
24.	Who is the role model for Professors? Is there training at home or school level?

2: Questions for Students

1.	What do you understand by the term professionalism in the context of medicine?
2.	What are the factors which affect professionalism?
3.	Does doctor's behavior differ from patient to patient? Do we behave differently with educated and non-educated patients or do we behave in the same way?
4.	If you are working in the hospital in backward area and you are also working at a high end private hospital, would you behave in the same way at both hospitals?
5.	Does our society and culture demand doctors to be the authoritative figure?
6.	Does lack of knowledge affect professionalism? If yes, how?
7.	Is there any effect of culture on professionalism? Would people living in different regions behave differently?
8.	If five years of medical education are not enough, then what time period is required to behave professionally?
9.	What should we do to promote professionalism?
10.	Is religion having an effect to strengthen professional behavior?
11.	Does culture play any role in professionalism?
12.	Is it important to satisfy the patient even if patient is wrong or is it important to do the right thing?
13.	Is there a code of conduct that you follow and if so how is it developed?
14.	Does monitoring have any influence on Professionalism?
15.	Does money affects professionalism?
16.	Who is responsible to develop the awareness in the society regarding professionalism and its values?
17.	Do doctors behave with all patients equally? Do they behave in the same way with the rich and the poor patients?
18.	Is professionalism affected by the reward and punishment system?
19.	Is spiritual treatment religious or cultural factor of society?
20.	Is there any relationship between humanism and professionalism?

3: Questions for Nurses

1.	What is medical professionalism**?** What are components of professionalism?
2.	Does your behavior effect your profession?
3.	Do the Nurses of private and public sector behave the same? How?
4.	What in your opinion is the role of culture in relation to professionalsim?
5.	Do you emulate your seniors? Do you follow what they are doing? Does this affect your professionalism and how?
6.	In your opinion what is the role of good communication and counseling in professionalism?
7.	If you don't behave well and treat patient and give him medicine and don't care for the patient what can be the affect?
8.	Is there any role of society or regulatory council in promoting professionalism? (e.g. Pakistan Nursing Council.)
9.	From where ethical values come from while dealing with patients?
10.	If you get job in private hospital and you are behaving very well with the patient, and after some time you get job in government hospital, would you behave in the same way in both organizations?
11.	In your opinion how does society and its values influence professionalism?
12.	How is the belief system derived?
13.	What do you think, are our beliefs derived from our religion or from our culture?
14.	What do you think, are religious values and nursing values interchangeable or not?
15.	Is there any difference in dealing with educated and non-educated patients?

4: Questions for Patients

1.	What do you think who is a good doctor and who is a bad doctor? On which scale would you call a doctor a good or bad one?
2.	What do you understand by the term 'medical professionalism'? Does this have any bearing in you deciding which doctor to visit?
3.	There are some doctors in hospitals whose attitude is very good but cure is not in their hands; what is your opinion about such doctors?
4.	Who is a better doctor; the one who charges more even if you can't afford him while you want to go visit that doctor for consultation or the one who takes less charges?
5.	Does the belief or faith of a doctor matter to you and why?
6.	In your opinion, a doctor who is a good Muslim would also be a good doctor?
7.	A doctor who is rich and owns car and house will also be a good doctor?
8.	What, in your opinion, are the reasons that a doctors treats differently in government and private hospital?
9.	Why do you think doctors suggest processing Lab Tests from outside the hospitals, when facilities for free tests are available in the hospital?
10.	Do you prefer a doctor who explains everything about the disease to you clearly or the one who takes decisions for you himself?
11.	Do you think you have any rights as a patient? And if so are they being respected by the doctors? How and why?
12.	Are you satisfied with the work ethics of doctors and how they deal with you?
13.	Are religion and culture separate or the same things?

5: Questions for Allied health Sciences Students

1.	Patients normally say that this doctor is good and professional and this doctor is not professional, what does this statement mean?
2.	What in your opinion is medical professionalism? What is its meaning, what do you understand by it?

3.	Does a doctor's perception and idea of being professional and patient's idea of being professional similar? How?
4.	How to control such factors which make 'Doctors', materialistic?
5.	Do patients complain that doctors do not show good behavior and if so why?
6.	Is there any role of monitoring in making a person behave more professionally?
7.	What do you think, are our beliefs derived from our religion or from our culture?
8.	What do you think, are religious values and nursing values interchangeable or not?
9.	Is there any difference in dealing with educated and non-educated patients?
10.	In your opinion, a doctor who is a good Muslim would also be a good doctor?
11.	Suppose you are not working well, is your behavior is not good is there anyone who can stop you or snub you?
12.	In your opinion what is the role of good communication and counseling in professionalism?
13.	Are religion and culture separate or the same things?

APPENDIX VIII

Reflexive Log

Some excerpts from the reflective log maintained during the course of this study are reproduced below:

24th March 2014

"The focus group discussion session at Lahore went well with the nurses today. There is a pattern that emerges out of all these focus group discussions that seems to put emphasis on the link between the society, its culture and practices and the 'kind' of professionalism being practiced. This should not come as a surprise. After all, the work places are embedded within the society, they are not foreign lands, alienated from the goods and bad in the society. Yet there exists a genuine desire to improve on professional values and work ethics at the professional level, even if it requires to stray beyond the limits of the society. But the apple doesn't fall too far from the tree, does it?"

15th January 2015

"Phew….at last…the last of the focus group discussions is finally over. Did I do too many? Probably? But, the more discussion groups I met, the more people I listened to, I could not help but notice that there are similarities and yet unique individual dissimilarities in the understanding of this phenomenon. Like this gentleman today, an allied health sciences student in Lahore was adamant that a belief in a higher being and retribution helps professionals behave well, and this has come up so many times in different groups, and yet each time there is a different, a slightly different connotation to it…like for example…the gentleman referred to above holds this belief because he is afraid of Divine retribution and

the patients always tend to say that if doctors behave badly with us, they will be punished by the Divine…classical hope claim of the less powerful when they feel helpless in the hands of the more powerful, in this case doctors, who they believe have power over them. But there are those patients as well who believe they will pray to the Divine to help them pass through a consultation session with a doctor with grace and less humiliation, no mention of Divine retribution by them…so, belief in Divine is both a safeguard and a hope for the patients and a means for the practitioners to keep themselves professionally sound…or is it?

APPENDIX IX

Wrapping up the juxtaposition of three case study approaches.

Juxtaposition of three case study approaches (Yazan, 2015).

Dimension of interest	**Robert Yin's Case Study Research: Design and methods**	**Robert stake's The Art of Case study Research**	**Sharan Merriam's Qualitative Research and Case Study Applications in Education**
Epistemological Commitments	Positivism	Constructivism and existentialism (non-determinism	Constructivism
Defining Case and Case Study	**Case** "a contemporary phenomenon within its real life context, especially when boundaries between a phenomenon and context are not clear and the researcher has little control over phenomenon and context" (p.13). **Case Study** is an empirical inquiry that investigates the case or cases conforming to the above mentioned definition by addressing the "how" or "why" questions concerning the phenomenon of interest.	**Case** is "a specific, a complex, functioning thing," more specifically "an integrated system" which "has a boundary and working parts" and purposive (in social sciences and human services) (p.2). **Qualitative case study** is a "study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p. xi). **Defining characteristic:** Holistic (considering the interrelationship between the phenomenon and its contexts); Empirical (basing the study on their observations in the field); interpretive (resting upon their intuition and see research basically as researcher-subject interaction); Emphatic	**Case** is "a thing, a single entity, a unit around which there are boundaries" (p.27) and it can be a person, a program, a group, a specific policy and so on. **Qualitative case study is** "an intensive, holistic description and analysis of a bounded phenomenon such a program, an institution, a person, a process, or a social unit" (p.xiii). **Defining characteristics:** Particularistic (focusing on particular situation, event, program, or phenomenon)**;** Descriptive (Yielding a rich thick description of the phenomenon under study); Heuristic (illumination the reader's understanding of phenomenon under study).

		(reflecting the vicarious experiences of the subjects in an emic perspective).	
Designing Case Study	Design refers to "the logical sequence that connects the empirical data to a study's initial research questions and, ultimately, to its conclusions" (p.20). Four types of case study design include single holistic design, single embedded design, multiple holistic design, and multiple embed design. Case Study design has **five component:** a study's questions; its propositions, if any; its unit(s) of analysis; the logic linking the data to the propositions; and the criteria for interpreting the findings. Qualitative and qualitative evidentiary sources should be combined.	Flexible design which allows researchers to make major changes even after they proceed from design to research. Researchers need a set of two or three Sharpened issue questions (research questions) that will "help structure the observation, interview, and document review" (p.20). He relies on Parlett and Hamilton's (1972) notion of "progressive focusing" which builds upon the assumption that "the course of the study cannot be charted in advance" (citied in stake, 1998, p.22). Exclusive use of qualitative data source.	Literature review is an essential phase contributing to theory development and research design. Theoretical framework emerging from literature review helps mold research questions and points of emphasis. **Five steps of research design:** conducting literature review, constructing a theoretical framework, identify a research problem, crafting and sharping research questions, and selecting the sample). Exclusive use of qualitative data sources.
Gathering Data	Data gathering is influenced by case study investigator's skills, training for a specific case study, the development of a protocol for the investigation, the screening of the case study nominations (making the final decision regarding the selection of the case), and	Being a qualitative case study researcher required "knowing what leads to significant understanding, recognizing good sources of data, and consciously and unconsciously testing out the veracity of their eyes and robustness of their interpretations. It requires sensitivity and skepticism"	Qualitative case study researcher needs to acquire the necessary skills and follow certain procedures to conduct effective interviews and careful observations and mine data from documents. Qualitative case study researchers utilize three data collection techniques conducting interviews,

	the conduct of a pilot study. Case study researchers make use of six data gathering tools: **Documentation, archival records, interviews, participant observation and physical artifacts.**	(stake, 1995, p50). Qualitative case study researchers exploit **observation, interview and document review** as data gathering tools.	observing and analyzing documents.
Analyzing data	Data analysis "consists of examining, categorizing, tabulating, testing, or otherwise recombining both quantitative and qualitative evidence to address the initial propositions of a study" (p.109)	Data analysis is "a matter of giving meaning to first impressions as well as to final compilations" (p.71). Simultaneity of data collection and analysis.	Data analysis is "the process of making sense out of the data… [which] involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read – it is the process of making meaning" (p.178).
Validating Data	**Five dominant techniques for data analysis:** pattern matching. Explanation building, time-series analysis, program logic models, and cross-case synthesis.	Two strategic ways to analyze data: categorical aggregation and Direct interpretation. Each researcher needs, through experience and reflection, to find the forms of analysis that work for him or her" (p.77).	Simultaneity of data collection and analysis **Six analytic strategies:** ethnographic analysis**,** phenomenological analysis, constant comparative method, content analysis, and analytic infection.
	Case Study researchers need to guarantee construct validity (through the triangulation of multiple sources of evidence, chains of evidence, and member checking), **internal validity**	Issue of data validation are involved in the notion of triangulation. **Four Strategies for triangulation:** data source	Qualitative methodology approaches differently to validity and reliability of the knowledge produced in research. **Six strategies to enhance internal validity:** Triangulation, member

	(through the use of established analytic techniques such a pattern matching), external validity (through analytic generalization), and reliability (trough case study protocol and data bases).	triangulation, investigator triangulation, theory triangulation, and methodological triangulation.	checks long term observation, peer examination, participatory research, and disclosure of researcher bias. **Three techniques to ensure reliability:** explanation of investigator's position with regards to the study, triangulation, and use of an audit trial. **Three techniques to enhance external validity:** use of thick description, typically or modal categories, and multi-site designs.

APPENDIX - X

ETHICAL DECLARATION

We undertake that:

We will abide by the declaration of World Medical Association (WMA) made at Helsinki (2008) regarding the ethical principles for medical research entitled **"A Comparative study of the Cultural Drivers Affecting Learning, Practice and Perception of Medical Professionalism in the UK and Pakistan"** involving human subjects such as:

1. The procedures shall be explained to the subjects clearly and expressed consent shall be obtained.
2. The confidentiality of the information shall be assured and maintained.
3. Data shall be used for publication only.

Prof. Junaid Sarfraz Khan
Student of Ph.D.
Prof. of Medical Education
University of Health Sciences
Lahore.

Prof. Dr. AslamKhan
B.Sc M.Sc. D.Sc. FFBSP. FFZSP.
FRSTM& H FPAMS.
Co-Supervisor
Head of Human Genetics & Molecular Biology
University of Health Sciences, Lahore

APPENDIX XI

ETHICAL REVIEW COMMITTEE
FOR MEDICAL AND BIOMEDICAL RESEARCH
University of Health Sciences
Lahore, Pakistan

The committee considers the ethical aspects of project entitled "*A Comparative study of the Cultural Drivers Affecting Learning, Practice and Perception of Medical Professionalism in the UK and Pakistan*" and the undertaking by investigators Prof. Dr. Junaid Sarfraz Khan, F.C.P.S (PK), F.R.C.S (Glasg), Dip MEd (Dundee) MEd (ELM) PhD (Med. Edu) and the Co-supervisor, Prof. Dr. AslamKhan, B.Sc M.Sc. D.Sc. FFBSP. FFZSP. FRSTM& H., FPAMS. to observe the conditions, laid down in the Declaration by World Medical Association at Helsinki (2008) regarding the ethical principles for medical research involving human subjects as:

1. The procedures shall be explained to the subjects clearly and expressed consent shall be obtained.
2. The confidentiality of the information shall be assured and maintained.
3. Data shall be used for publication only.

Further, the members perused the project and were satisfied with the undertaking of the investigators.

Prof. Dr. Mohammad Tahir, Chairman of Ethical Review Committee, UHS. Lahore	**Prof. A.H. Nagi,** Member of Ethical Review Committee, UHS, Lahore	**Prof. Aslam Khan,** Member of Ethical Review Committee UHS, Lahore

APPENDIX XII

Participant Information Sheet and Consent Form

PARTICIPANT INFORMATION SHEET

"Understanding the stakeholders' perspectives on professionalism in healthcare: A cross-cultural analysis"

Assalam o Alaikum,

My name is Dr. Junaid Sarfraz Khan and I am a PhD Scholar at the University of Health Sciences Lahore. Some of you may also know me as the pro Vice Chancellor of that University. The PhD Research project titled "Understanding the stakeholders' perspectives on professionalism in healthcare: a cross-cultural analysis" is a Higher Education Commission Pakistan funded project won by me through open competition. Successful completion of the research and defence of the thesis may lead to the award of a PhD degree from the University of Liverpool, UK.

The purpose for conducting this research is to understand what medical professionalism means to various groups of people individually and collectively. These groups include nurses, allied health sciences students, medical students, doctors, policy makers and patients.

Understanding what meanings these stakeholders develop and also how they develop these meanings will help in educational policy-making within the health professions not just in Punjab but across the globe. Moreover, the findings from this study will go on to inform future researchers as they endeavour to undertake further research in this area.

I am reaching out to you to kindly facilitate me in my research endeavor by agreeing to participate in a discussion together with your colleagues from your institution. The discussion will be in a secluded, quiet environment and shall be audio-recorded and at the same time I, myself and a colleague will be taking notes. The discussion will revolve around your understanding and lived experiences regarding medical professionalism and I shall facilitate the discussion process. Nothing you say shall affect your status and position within your organization. All the recordings, notes and transcriptions of audio-recordings will be kept confidential. Safety, confidentiality and anonymity shall be maintained throughout the research process. Real names or even designations shall not be used. Indeed the name of your institution will also be kept confidential.

Please note that you may choose not to take part in this research or choose to leave the study at any time, whence your data shall be safely destroyed and never used.

Please feel free to ask any questions regarding your involvement in the research project. I certainly hope that you will agree to participate in the discussion. The discussion is not likely to last for more than hour or so.

Kind Regards

Prof Dr Junaid Sarfraz Khan

Tele: 0092324430217

PARTICIPANT CONSENT FORM

"Understanding the stakeholders' perspectives on professionalism in healthcare: A cross-cultural analysis"

I _____ s/o-d/o _____ , resident of _____, contact no._____ , email address_____give consent on _____/ _____/ 201____ to participate in the focus group discussions for the research project of Dr. Junaid Sarfraz Khan titled as above. I give this consent freely after reading and understanding the information provided in the 'PARTICIPANT INFORMATION SHEET' provided to me by the researcher or his colleague. I also understand that all my data shall be kept confidential and my identity and that of my institution shall never be disclosed.

I am aware that I have the right to leave this research project at any point during this study, in which case the data that comes from me shall never be used and destroyed.

Signature of the Participant Signature of the Researcher