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

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Abstract

Background: Professionalism is amongst the major dimensions indicating the competence of medical doctors. A low professionalism affects the overall outcome of healthcare services. This study explores the perspectives of young medical doctors on professionalism in Pakistan.

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

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

Conclusions: Findings implied low medical professionalism among young doctors. This should be immediately addressed by policymakers. Lack of training about professionalism, ethics and humanity in healthcare service delivery, and a lack of performance monitoring and evaluation mechanisms at public hospitals are the major factors contributing to this substandard medical practice. There is a need to revisit the curriculum taught to medical students in order to strengthen professionalism. It is important to improve the skills of being ‘teachable’ and to provide acceptance of other viewpoints in cases where interprofessional collaborations are to be established by medical doctors.

Background

Medical professionalism is one of the key components of the doctor’s toolkit, and comprises technical expertise, interpersonal skills, time management skills, and medical competence. Clinical excellence cannot be achieved unless a doctor has high personal values such as altruism, empathy, respect for human life and good conduct (1). Professionalism fundamentally is defined as a set of attitudes and behaviours that serve as the foundation for services rendered by an individual towards society (2). Every profession has ethics which is grounded in the functions performed. The American Board of Internal

Medicine identified seven universal components of medical professionalism: excellence, empathy, self-denial, accountability, duty, rectitude, and respect (3). Empathy towards patients is the most important after excellence and may be defined as the ability to understand a patient's perspective and support him or her (4). Empirical evidence revealed that empathy may be diminishing in the doctors' practice due to their mistreatment by seniors and training for impersonal associations with subjects, during their time at medical school, which is a threat to their professionalism and the overall quality of healthcare (5).

We define medical professionalism as a belief system in which doctors promise to uphold in their work, an adherence to ethical principles and respect for human diversity (6, 7). Studies conducted in China have demonstrated that a lack of medical professionalism is connected to irresponsibility, procedural errors, conflict within medical teams, and monetary concerns (8). Scholars have compared the professionalism among medical students and faculty of a medical university in Saudi Arabia. They stressed the importance of academic integrity as well as teaching and learning of medical professionalism (9).

International studies on medical professionalism showed that professionalism is an important quality when identifying a 'good doctor' besides the technical and communication skills (10, 11). A study conducted in the United States of America assessed the medical professionalism perceptions of medical students undergoing pre-clerkship and highlighted attributes of dependable and non-maleficent medical professionalism (12). This research demonstrated some least discussed aspects of medical professionalism that are keeping personal beliefs separate from medical advice, tolerance and helping colleagues. The fundamental spectrum of attributes of medical professionalism is based on three levels: individual, doctor-patient, and community (13). Scholars have been devising means of improving the professionalism of doctors through teaching additional courses as part of the formal curriculum and introducing training sessions on humanism in medicine. Klemenc-Ketis and Kersnik (14) have experimented with the use of movies to increase the level of professionalism among medical students by depicting ideal situations involving positive behaviour and scenarios of rich resource settings.

Pakistani context

The health services in high-income countries are continuously progressing away from a traditionally paternalistic approach towards a more patient-centred and egalitarian, collaborative approach to doctor-patient relationships (15). However, the medical doctors in Pakistan have been resistant to accepting the validity of modern approaches of doctor-patient relationship (16), which may determine a low medical professionalism.

There has been some debate about the quality of medical graduates over the last two decades and the medical professionalism of young doctors serving in public-sector hospitals in Pakistan (9). Previous studies in Pakistan have focused on the qualities a good doctor should possess with reference to the patients. Only few have demonstrated that the medical community is trying to respond to this lag in professionalism by means of conserving, researching, teaching, and evaluation (17, 18). Young medical graduates have socially constructed attitudes of superiority to other professions, because only the highest performing students in the education system become doctors in Pakistan. Familial pride is

associated with their high-performing children when they succeed in qualifying for medical school. This generates a sense of superiority among both medical students and practitioners. The significance of the present study lies in the demonstration of this contextual aspect of medical training. No previous study from Pakistan has highlighted this fact.

The behavioural problems among doctors is maybe linked to an absence of professional spirit directed towards serving humanity, stubbornness about accepting other points of view, the subjectivity of human nature and breaches of the Hippocratic Oath (19). Furthermore, structural problems such as long working hours, low salaries, and unfavourable working environments have adversely affected medical professionalism. In high-income countries, medical graduates are well trained in using human and professional skills to deal with patients in an empathetic manner (20). However, there is huge variation in the standard of professionalism in high-income and poor countries (21). Previous high opinion of the medical profession among patients is also going through a regressive change. Patients do not regard doctors with titles as life savers, rather they call them butchers performing experiments on the poor people (16).

In Pakistan, students who demonstrate extraordinary academic performance and are positioned at the top of the merit tables are recruited into the medical profession. After working hard for many years, they remain unpaid or underpaid (22). The struggling doctors in Pakistan are protesting peacefully about the causes of low payment, hectic work schedules and job insecurity (23, 24). Abbasi (22) highlighted that the problems faced by doctors adversely affect the experiences of patients and lead to the departure of highly capable medical doctors from Pakistan. The prolonged suffering, delayed provision of medical care facilities, potential loss of health, lack of job security, unpaid service, and non-recognition of services rendered are the factors associated with strikes by young doctors (25).

This study provides a lens to medical professionalism from the perspective of young doctors themselves. This study has international relevance, because the unprofessional behaviour is not openly discussed. Like other areas of public health, professionalism has also not been extensively explored in Pakistan. Only one study examined professionalism among medical students in Pakistani university using quantitative methods (17), but no previous work is available that examines professional behaviour among young doctors with purely Pakistani heritage. Thus, this study aims to explore the perceptions of young medical doctors about professionalism, and the facilitators and frictions towards professional behaviour. In this regard, we focused on the following research questions: How professional do the doctors think they are? How do they perceive the structures, processes and outcomes of medical care affect their medical professionalism? What is the nature of problems that doctors face hindering their ethical medical practice?

Methods

Study design

Since the purpose of this study was to understand the medical professionalism among young medical doctors of Pakistani heritage, the interpretive ontological and epistemological stance was adopted. An exploratory qualitative study was conducted, because the finest elicitation of the contextual and normative factors is attained through in-depth interviews.

Participants

Data was collected from 60 young medical doctors. The participants were identified using a multistage maximum variation sampling method (26). In first stage, the hospitals were selected, based on the criterion that the largest public-sector teaching hospitals in three regions within Pakistan (Sindh, Punjab, and the State of Azad Jammu & Kashmir) be included. The major public-sector, tertiary-care hospitals were sent written requests explaining the purpose of the present research. The study was carried out in the consenting hospitals. In second stage, criteria sampling was done to recruit participants who were young doctors (less than 40 years of age) in the early years of their professional careers, who were working at various hierarchical levels as house officers, medical officers, trainees, senior registrars and specialists, in various specialities and departments (Table 1). The doctors of physiotherapy, dentistry or nutrition have not been recruited in this study. We focused on the medical doctors only who obtained an undergraduate, first professional degree in medicine (MBBS) from Pakistani universities. Maximum variation sampling was used to recruit doctors of all possible ranks deputed in various departments of the selected hospital.

Table 1: Multistage maximum heterogeneity sample calculation

Sampling stage 1	Selection of hospitals	Criteria: Largest public-sector teaching hospital in provinces of Sindh, Punjab and the State of Azad Jammu & Kashmir (AJ&K)	1 hospital in Punjab 1 hospital in Sindh 1 hospital in AJ&K
Sampling stage 2	Recruitment of doctors	Criteria: 1. Age: 24 to 32 years / 33 to 40 years 2. Gender: male / female 3. Service level: house officer, medical officer, PGT trainee, senior registrar, specialist	Calculating factor: 2 x 2 x 5 = 20 doctors selected in each hospital

Interview guide

A semi-structured interview guide was developed based on an extensive literature review. The respondents' profile attributes included: gender, age, nationality, qualifications, designation, area of specialisation, and length of service. The interview guide included open-ended questions about: reason for becoming a doctor; hardships and gratification; understanding of the meaning of professionalism in medicine and qualities of ideal medical doctors; young doctors' perceptions of patients (ridiculing the patient, treating them as subjects, justified misbehaviour); perceptions of flawed technical expertise (procedural errors, absence of physical examination, and inability to diagnose without pathology tests); dealing strategically with security issues and safety at work; personality traits (patience, tolerance, flexibility, altruism, service to humanity, high moral standards, integrity, honesty, and duty); process and structural factors hindering professionalism; self-pride and shaming of other professions; and what has to be done to improve the situation (Additional file 1).

Ethical approval

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

Data collection

The interview guide and respondents' answers were all in the English language. The interviews were conducted by the first author and a research assistant. The research assistant was a graduate, had prior experience of qualitative data collection in health settings and went through pre-interview trainings. The doctors were interviewed in doctor offices during break and duty closure, as per their convenience. We ensured privacy during the interview and data security after audio recording. Any information that could identify the doctor was not transcribed. During the initial days of the research, the doctors gave socially desirable answers and were not willing to give much time perhaps due to busy work schedule or lack of interest in the subject matter of research. Off-record statements and comments of doctors have been noted for further usage in data analysis. The data collection was completed during April and May 2019. The interview time ranged from 30 minutes to one hour and fifteen minutes.

Data analysis

Data analysis took place after completion of data collection. The data were analysed through qualitative thematic analysis. We followed the 32-item checklist *Consolidated Criteria for Reporting Qualitative Research* to report the findings of this research (27, 28). To ensure inter-rater reliability, the first author and research assistant coded the data. Both researchers mutually discussed coded data to compare the coded data and arrive at common and variant codes. The codes were grouped into common themes.

Finally, the themes were grouped into categories and relationship identification was done. Additional file 2 exemplifies the codebook. Upon completion of data analysis, the findings were taken back to three of the same study participants, who expressed their interest during the interviews in order to ensure the credibility.

Results

Throughout the data, we found that the perceptions of young doctors demonstrated a low medical professionalism. Occasional self-comparison with the doctors in previous generation implied a decline in the spirit of serving humanity. The findings are based on analysis of the reporting of participants and observations of researchers in data collection. Overall, sixty participants were interviewed with equal representation of all three selected regional hospitals. The characteristics of participants are presented in Table 2.

Our analysis demonstrated the following categories of medical professionalism linked with how professional, young doctors think they are and how their attitudes diverge away from standards of professionalism, the structure, process and outcome factors affecting their medical professionalism in public hospitals in Pakistan.

Table 2: Characteristics of participants

Characteristics	Punjab	Sindh	Azad Jammu & Kashmir
Age			
24 to 32 years	10	10	10
33 to 40 years	10	10	10
Gender			
Male	10	10	10
Female	10	10	10
Highest qualification[1]			
MBBS	4	4	4
FCPS1	4	4	4
FCPS2	4	4	4
Diploma	4	4	4
Others	4	4	4
Service level			
House officer	4	4	4
Medical officer	4	4	4
PG trainee	4	4	4
Senior registrar	4	4	4
Specialist	4	4	4
Service length [2]			
Less than 7 years	12	9	13
7 to 12 years	8	11	7
Department			
Outpatient	7	8	7
In-admission	6	6	7
Emergency and accidents	7	6	6

[1] Qualified in Pakistan are selected. Doctor of Physiotherapy (DPT) and Bachelor of Dental Surgery (BDS) are not recruited.
[2] Average age of completing MBBS (MD) is 23 to 25. This experience includes one year of house job.

Flexibility, tolerance and low medical professionalism

The study participants showed characteristics such as rigidity of opinion, inflexibility, and non-acceptance of contrasting perspectives. Some of the doctors became angry during the interview about the subject matter of the research and regarded it as a strategy to make doctors furious. The statement of one respondent may be useful at this point to further clarify the scenario: *"I don't understand why you're carrying out such research. This is not your field – you're not a medical doctor. A doctor of medicine can ask us such questions."* Another respondent said: *"Because of this type of research, doctors are unable to perform well on duty."* No demonstration of acceptability was recorded in such cases. Constructive criticism should also be welcomed by professionals.

One study participant said about the need of tolerance: *"I think to some extent tolerance is good, but it becomes negative if we use it everywhere like we will forget to even react on situations where reaction is actually needed. So, it has less to do with our field."*

The young doctors believed that they are superior and there should be no collaboration with experts of other fields. Only a medical doctor has the capacity to work with public health related matters. There is no need for the inclusion of a professionalism and humanity course in the medical school curriculum. The majority of respondents thought that social science topics are irrelevant to medicine and are merely common-sense things that they already know. Individually, doctors reported that they are highly professional, but some others demonstrate unprofessional behaviour. These reported characteristics include using social media applications during duty hours, ridiculing patients, substance use such as cigarettes in the office and inappropriate salaries.

Perceived superiority and paternalistic approach

We found that the perceived inferiority over all other professions and patients were highly prevalent among the participants and leads to the demonstration of false pride. Most of the participants reported that the tolerance and acceptability have less to do with medical professionalism. A doctor said: *"A doctor is a 'doctor'."* All participants (n=60) believed that their knowledge of medicine has equipped doctors with a superior position over their patients and other professions. The belief that patients know nothing was common among all the participants. One female doctor said: *"A down-to-earth approach wouldn't work for patients in Pakistan. Patients don't mind the harsh conversation by the doctors, rather they think that a doctor who snubs is a competent doctor".* Another respondent said: *"Patients know nothing irrespective of the fact that he is educated or not – obviously one would not become a doctor by googling diseases and symptoms".* This statement reveals a sense of superiority over patients and other

human beings. The doctors demonstrated a lack of any perceived need to establish congruence with patients.

Training under positivism

Almost all the participants vested medical professionalism in themselves and reported other doctors as having distorted professional ethics. The training under positivist school of thought does not leave any room for subjective human nature. This is depicted in the words of our participants who believe that humanities, ethics and professionalism are common sense phenomenon and since medical doctors pass through the toughest educational screening and training, they do not need to learn these skills. There was reporting about clash of opinion and patty issues among the doctors, which reveals lack of acceptance of other viewpoints and rigidity perhaps linked with medical school training under scientific knowledge trends.

Seriousness towards duty

For example, we were told that medical doctors use mobile phones while seeing patients. This is a common practice among doctors in Pakistan, which affects the quality of attention they give to patients. Furthermore, smoking and substance use by male doctors has also been reported by female as well as male doctors.

Ridiculing the patient

There was reporting of sub-standard incidents of laughing at in which senior doctors discuss critical patients in debriefings to house officers. Making fun of those who are in pain and dependent for help on the doctors on duty does not imply medical professionalism. The words of a house officer doctor clarify this finding: "*I became a doctor to serve mankind and I have tried my best to do my duty honestly. I feel depressed when I see my colleague house officers ridiculing old patients admitted in critical condition. None of the house officers want any patient to expire on their bed so they refer patients to other public hospitals without treating. Even it was depressing for me when I heard MO making fun of old patients in pain. (Probe: What did MO say while making fun? If you can recall?) Yes, he came in and asked his house officers: How many elderly patients do you kill today? And it was happening everyday as fun routine in meeting of house officers with MO."*

Inadequate role models

During the first sessions, the doctors gave socially desirable answers, such as: "*We're very professional and none of the doctors show aggressive behaviour on duty"*. However, later on, the respondents emphasised that aggression is a basic part of human nature. In conflict situations, both parties are justified in demonstrating aggressive behaviour. Participants reported that the seniors and colleagues who are rude and critical and create conflict are just following human nature. None of the participants mentioned the need for anger and conflict management. Mistreatment by seniors and a high workload were reported by a few respondents. The seniors should set good examples for the young doctors to

follow, said one respondent: *"When they are not coming on time and insult patient on single question, how can young doctors follow their trends? They have clashes with others. They criticize each other on disease management strategies – even wouldn't agree on the doze of anaesthesia."*

Intermediary non-medical staff

Several practical issues have been reported about working in healthcare teams, and non-cooperation of paramedical and nursing staff. The treatment errors are linked with the non-cooperation from non-medical staff, especially nursing assistants, during the execution of medical procedures: *"The government initiatives have made the nurses superior to the doctors by giving them job security and reasonable salaries that exceed what is paid to the doctors. So now the nurses clash with doctors – even during operations they do not cooperate with us… Like during surgery that I asked for retractor from nursing staff, she didn't respond so I asked again she kept standing silently and then I had to go further away and get it myself."*

Due to the status of the job and facilities in the public sector, nursing staff often clash with doctors. Technically, the doctor is head of a healthcare team, but the situation is different in public hospitals in Pakistan. Female doctors expressed their fear of abuse from nurses in case failure in making them happy and provoking anger on petty issues: *"In gynae wards, it is very important for all house officers to have good 'Hello' or 'Hi' with nurses, because if you annoy them and cross them, they will not do anything for you so we call them nicely as baaji jee (in Urdu) meaning elder respectable sister."*

Another female trainee doctor said: *"We have to call the nurse in a low and sweet tone so she may give us the thing that we need. All of the senior doctors even call the nurse as nurse 'jee'"* (in Urdu, *jee* is used with names to show extreme respect). Participants told that the patients also complain about the non-cooperation by the nurses. One of the doctors reported that she has heard a nurse putting off the patient by saying: *"I'm busy now – come tomorrow. I will tell you how to use insulin, diet chart and check blood sugar…"*

Ethical medical practice

There was incongruence in the perceptions of doctors on what describes ethical medical practice. The majority asserted the importance of technical aspects of medical care. We found few responses in favour of service for humanity, sacrifice and honesty. Only one male trainee doctor spoke about what professionalism is: *"A good doctor sacrifices his sleep and appetite so that his patient could sleep well"*. Overall, only two doctors said that they are serving humanity and emphasised that the purpose of joining this profession was not the monetary benefits: *"How can people expect from doctors to think of serving humanity when they are having financial problems at home. Their families also need money for survival and a good quality of life. Doctors should be highly paid, because they have worked harder than people in any other profession. For following standards of what is right and wrong, there has to be overall workplace environment that would allow us do that."*

Need for accountability and training

The respondents agreed that a mechanism for accountability is required in hospitals but emphasised the need to appoint a medical doctor with expertise in evaluation. This suggested that medical doctors would not like to be watched by a person with a non-medical background. Few mentioned about low professionalism in general but at the same time reported that training on the non-technical aspects (i.e. interpersonal communication and professionalism) in their degree programmes is not needed. They still viewed it as irrelevant content.

'Teach-ableness' of doctors

While disagreement with experts of other fields, it is observed that that doctors are not teachable and lack acceptability for other viewpoints. Something is seriously lacking in the training at medical schools. This can be understood clearly in the words of a respondent of this study who said: *"How can a social worker or a lawyer tell a doctor what to do in healthcare practice? The other professions are adopted by people of average intellectual and mental abilities. A doctor is a 'doctor'. If something must be done about society or there is any kind of program evaluation, healthcare should be assessed by a medical doctor. There is no need for social scientists and humanities in here."*

These statements demonstrate the irrational sense of personal value and false pride that doctors have in medical profession. However, it can be understood only when contextualized in South- Asian society. This implies that the doctors are not teachable and have no skills of tolerance and acceptability.

Work in interprofessional collaborations and conflict management

There was no tendency for working in interprofessional collaborations as doctors felt that they do not need and trust services from experts of other fields since those are opted by low performing students. This attitude is not professional in nature.

The findings also implied that there are clashes of opinions within the team of doctors over prescribed treatment and procedures. The effectiveness of teamwork in healthcare is associated with patient outcomes. Respondents justified to be in conflicting situations frequently with other doctors and healthcare providers. A female doctor said: *"It is normal and healthy to get into arguments and conflict."* Another said: *"We cannot avoid getting into conflict because it is natural and has no harm"*. Low concern about learning conflict management skills was found.

Discussion

A large number of empirical studies have already demonstrated various components of medical professionalism (29). This study explores the perceptions of medical professionalism among 60 young doctors and provides a qualitative account of low professionalism. Our results indicate that young doctors are low on professional ethics due to personal, procedural, and structural factors. Even though the profession cultivates humanism, the findings are quite contradictory and question the quality of

medical education in Pakistan. Medical students only learn professional values informally through the role model method because the national curriculum for medical universities does not comprise courses on ethics and professionalism. Medical professionalism is not taught explicitly at medical colleges or medical universities in Pakistan.

In countries like Pakistan, parents always ask their children to opt for medical science as a profession. This is due to the misleading suppositions about the possibilities of getting highly paid jobs and the social prestige attached to this profession. This social prestige is also contributing to the false pride among young doctors. Studies in the rich resource healthcare settings also demonstrated incidence of significant degree of arrogance in new medical doctors during the pre-clerkship (23). Parents invest heavily in their children's education in order to make it possible for their children to gain admission to medical science courses. Consequently, once a student secures admission to medical college, he/she and his/her family take pride in this achievement. In addition, medical colleges exist in a kind of environment where their students have always been considered more successful than students who are studying in other fields. In such a scenario, medical students feel themselves superior to others, although a lesser amount of money is spent on the healthcare sector, particularly for medicines (23). There is no previous empirical study that validate these contextual realities. Our respondents have highlighted their struggle and pressure from families at the time of getting admission in medical universities.

This is supported by our study results, because the young doctors believe themselves to be superior over other people in other professions and patients. Addressing such attitude problems is a dire need of time because it is manifesting in the display of medical professionalism. Listening to the viewpoints of patients about their health helps doctors to uncover possible reasons for ailments, but doctors' sense of superiority does not allow them to fully understand the condition of patients (11, 12). Learning of patient centred medical practice is a prerequisite.

It seems as if the education system in Pakistan evaluates candidates on ability of memorization merely. But the ability to diagnose with accuracy is a skill, not possessed by all the medical doctors produced. Therefore, most young doctors do not achieve the standard of diagnosis that a successful doctor should have. Moreover, the success of healthcare procedures depends on cooperation between the entire healthcare team: doctors, nurses and other non-medical staff (24). However, young doctors frequently report non-cooperative behaviour by the non-medical staff. One possible reason for this non-cooperation is that young doctors are not capable enough to express their concerns based on equality. However, research demonstrates that most doctors do not know how to treat their subordinates in emergency situations. Not only do they misbehave with their subordinates, but they also have the same attitude towards the patients and their attendants, particularly those who belong to lower social classes (16, 25). Doctors believe that good medical practice is hampered by external factors related to structure and process. Occasionally, this resulted from the comparison with medical doctors who started practice three decades before. In this regard, they pointed out other reasons such as the senior doctors as their role models. They blame senior doctors because they always criticise their juniors and disrespect them. They are also not satisfied with their role models and supporting paramedical staff. This supports the previous

studies that have asserted the importance of learning from the role models (30). However, it is also important to be able to work in interprofessional and healthcare teams (31, 32).

The foremost reason for lack of seriousness towards duty is excessive mobile phone and internet use. Previous research also confirms our finding that the use of mobile phones and social media is quite common among Pakistani doctors during their working hours (33, 34). Furthermore, it is alarming that young doctors do not judge the use of mobile phones and internet during duty hours as being determinant of medical professionalism (35). A study on medical students demonstrated that the use of Facebook by the young doctors blurs the professional boundary between patient and doctor (36).

To provide better healthcare, it is necessary to train doctors in the skills that will make them successful professionals. One needs to consider that professionalism is investigated as a culturally delicate phenomenon and a competency-based training for undergraduate medical students should be designed as context specific (37). Furthermore, the qualitative approach allows further insights but not a representative overview, although the sample is large. Future studies may develop a comprehensive scale to measure medical professionalism in Pakistani graduate doctors. Studies may examine how the professionalism increases when Pakistani young doctors seek jobs in wealthier countries.

Limitations and strengths

There were certain limitations of this study. The previous research conducted in Pakistan suggests that the medical professionalism is high among medical students (17). In contrast, the present study did not measure professionalism quantitatively. In addition, findings may not be representative for Pakistan, as the study has been conducted in only one province. The effects of sample selection and response biases may have influenced our findings.

However, we attempted to avoid researcher bias in designing interview guide, data collection, analysis and reporting. The interview guide was developed based on the deduced concepts that emerged in the literature review. The context-based questions were phrased formally and specifically. The interview guide did not carry any suggestive or pushy question. The data collection and analysis were performed by two researchers. For reporting the findings, the quotes from participants were cited. The interviewers did not react to critical and aggressive responses. This research theoretically contributes to the body of literature by delineating the perspective of young doctors on their medical professionalism.

Conclusion

Our findings demonstrate a low medical professionalism among young medical doctors. This is indicated by false pride, lack of willingness to work in interprofessional collaborations, shaming other professions, perceived sense of superiority over patients, ridiculing patients, use of mobile phone and social media at work, and medical errors. Lack of flexibility, low teachable-ness and acceptance of other viewpoints were commonly observed in the data. Structural frictions of professional medical practice included ineffective role models, non-cooperative nursing staff, low salaries and insecure nature of employment. Occasional

self-comparison with the doctors of previous generation implied a decline in the spirit of serving humanity. Any act of malpractice damages public trust in the medical profession and affects the quality of the physician-patient relationship. Patient-centred healthcare service delivery refers to an increased concern for patient satisfaction and lies at the foundation of medical professionalism in this era. The new values of medical professionalism and worth of the patient as an equal should be emphasised to a greater extent in the training of medical students. Self-improvement is an important aspect of medical professionalism, which cannot survive with false realization about the completeness of one's knowledge. Better role models can help uplift the professionalism, which is achievable by organizing faculty development workshops (38). Prospective research should focus on developing strategies and methods for raising medical professionalism in the medical universities.

Declarations

Ethics approval and consent to participate

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

Consent for publication

Not applicable

Availability of data and materials

Pseudonymized transcripts are available upon reasonable request.

Competing interests

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

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Authors' contributions

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

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Additional Files

Additional file 1: Questionnaire

Additional file 2: Exemplar codebook

Supplementary Files

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