

Physician Reported Challenges to Medical Professionalism: A Qualitative Study of Clinicians From Northern China

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Abstract

Background

Despite efforts to promote professionalism among physicians, many studies have confirmed the ongoing prevalence of unprofessional behaviours in medicine and alluded to the challenges to professionalism that physicians may encounter. Physicians may regularly witness unprofessional events and may even participate in unprofessional practices. Therefore, the current study aims to identify common challenges to professionalism and physicians' priorities when coping with such challenges—in hopes of shedding light on the East Asian environment with respect to physician professionalism.

Methods

Five focus groups were conducted with a total of 49 clinical physicians from two tertiary hospitals in Shenyang, the largest city in northern China. Socio-demographic data were obtained through a brief questionnaire, and participants were de-identified after being linked to verbal data from the focus groups. Focus group interviews were audio-recorded and later transcribed and subjected to an inductive thematic analysis.

Results

A content analysis of the focus groups demonstrated that common professionalism challenges could be classified into five categories, namely: patients and their families (38%), society (22%), peers or teams (21%), institutions (13%), and education (n = 6%). Physicians failed to find current remediation measures, such as, discussing with supervisors, or reporting challenges to hospital or health authorities very effective.

Conclusions

The current study suggests that challenges from patients and their families contributed the most to professionalism challenges in the hospitals in northern China. In terms of the systematic reform of medical education and the healthcare delivery system, health authorities and hospital administrators should aim at addressing challenges to physician professionalism by building up a protective atmosphere.

Background

The deterioration of the physician-patient relationship and increasing problems within the health care setting have become emerging topics affecting both quality of care and physician wellbeing [1,2]. As evaluations of physicians by patients and by society become increasingly rigorous, physicians are also experiencing declines in patient trust [3,4]. In light of these challenges, physician professionalism underpins the quality and delivery of health care and addresses many of its underlying issues [5]. Therefore, medical educators have increasingly stressed that the training of medical students should not

only be limited to the mastery of clinical knowledge and skills but should also extend to professionalism training. Evidence of this is seen in the growing research on professionalism education [6-10]. However, despite considerable advances in the incorporation of professionalism into the formal curricula [11], situations may still arise that are ethically clear but simultaneously impossible to execute to those standards [12].

Over the years, institutions and researchers in various countries have conceptualized professionalism at three levels, namely the individual, interpersonal, and societal/institutional [13]. From this perspective, professionalism can be thought of as something that is stable and internalized, that comes out of the relationship between people, and that spans large scales, respectively [14]. It is impossible to understand all aspects of professionalism without considering the practice of medicine and emphasizing its normative requirements [15]. Therefore, effective professionalism training and remediation would need to incorporate the actual needs of those in the medical field.

Although there are numerous studies on challenges to physician professionalism, most analyse factors that produce professionalism challenges from a macro perspective [16-23], such as cultural considerations, social accountability, global environmental changes, and finance. Although one study mentions the challenges that surgical innovation brings to professionalism, the motivation for innovation is also often related to social context [24]. While most of these studies have identified the regional, cultural, and financial challenges to professionalism, few have investigated the actuality of these situations, especially from the individual perspectives of physicians, or explored actions to resolve those issues.

The current study aims to identify common challenges to physician professionalism in northern China and physicians' most demanding needs when coping with such challenges and to subsequently provide insights on the design of professionalism curriculums and improvement of the professional environment under similar sociocultural settings. A secondary aim of the current study is to encourage readers from various countries to also reflect on the professionalism environment in their regions.

Methods

Participant recruitment

Participants were recruited across all clinical departments and specializations from two tertiary hospitals in Shenyang, China, between December 2016 and January 2017. Hospital and department administrators assisted in disseminating recruitment information. Participants across multiple departments volunteered for the study but were required to be employed full-time by the hospital; any visiting professionals were excluded. Participation in the focus groups was voluntary, uncompensated, and anonymous, and participants could withdraw from the study at any time. Participants signed written informed consents and approved anonymous use of data after de-identification.

Focus groups and data collection

Focus group participants were welcomed and introduced to the concept of professionalism challenges. Participants were then divided into three different focus groups, with ten people in each group. Two research personnel (HHL and WYZ) facilitated each focus group to discuss the following three questions: (1) “What is your understanding of professionalism challenges in clinical practice?”; (2) “How do you deal with professionalism challenges?”; and (3) “In your opinion, what contributes to professionalism challenges?”. An analysis of themes in physicians’ challenges from the focus group discussions was conducted after the third focus group. Researcher discussions and the analysis of themes concluded when no new themes emerged. The focus group discussions reached saturation by the fifth group, during which no new themes emerged.

Data analysis

Group discussions were audio-recorded, transcribed, and kept confidential. A primary thematic analysis of the data was done using five stages. The interview data were analysed based on inductive thematic analysis using NVivo Version 10 (QRS International, Burlington, MA) [25]. First, two research personnel (ND and WYZ) open coded all transcribed narratives independently. Second, the coding results of different researchers were sorted, and the data was classified into conceptual components. Third, the researchers reflected on the readings and understandings, continuously comparing similarities between each participant. Fourth, the researchers distinguished between the categories and connections, identifying the core categories. Fifth, the data was charted, and all researchers discussed and collectively agreed on the professionalism challenge themes based on the coding. Finally, the themes were compared and contrasted to the existing literature.

Results

A total of 49 physicians were recruited and divided into five focus groups. As shown in Table 1, the majority of participants were female (n = 31), younger than 30 years old (n = 30), held master’s degrees (n = 38), and had shifts of 8 to 10 hours (n = 32). The participants primarily came from internal medicine and surgical departments. In total, 109 narratives were obtained from the participants during the focus group discussions.

Table 1. Selected characteristics of the study sample (n = 49)

Characteristic	Students (n, (%))
Gender	
Female	31 (63.3)
Male	18 (36.7)
Age group (years)	
Less than 30	30 (61.2)
31-40	17 (34.7)
41-50	2 (4.1)
Education	
Bachelor	2 (4.1)
Master	38(77.6)
PhD	9 (18.3)
Specializations	
Internal medicine	22 (44.9)
Surgery	17 (34.7)
Paediatrics	6 (12.2)
Others*	4 (8.2)
Length of work shift	
Less than 8 hours	3 (6.1)
8-10 hours	32 (65.4)
10-12 hours	11 (22.4)
More than 12 hours	3 (6.1)

*Obstetrics and gynaecology, emergency medicine, and otorhinolaryngology (ENT)

Themes in physician-reported challenges to professionalism

The following professionalism challenge themes were summarized from the open codes assigned by researchers, with some narratives involving multiple themes: (1) patients and their families (n = 41, 38%); (2) societal (n = 24, 22%); (3) peers or work teams (n = 23, 21%); (4) institutional (n = 14, 13%); and (5) educational (n = 7, 6%). Table 2 shows the descriptions of each theme and the corresponding illustrative narratives.

Table 2. Types of professionalism challenges faced by doctors, with examples and quotations from focus groups

Themes in	Sub-content	
professionalism challenges Patients and their families (n = 41)	a. Patients and their family members do not trust physicians.	"Once, when I was performing an orthopaedics procedure, the patient's family members recorded and took photos of the whole process using their smart phones, which made me very uncomfortable. Seriously, what made it worse was that, they did not stop after I had asked them to." (1A, F, 35 years)
	b. Patients and their family members do not respect physicians.	
	c. Physicians cannot communicate effectively with irritable patients and/or their family members.	
Society (n = 24)	a. The public are prejudiced toward medical professionals.	"When we accept severe patients we are very cautious, because if the cost of treatments exceeds the coverage of medical insurance, doctors may compensate this shortage with their own money." (5E, M, 33 years)
	b. Inaccurate understanding of the nature of health service.	"Patients lack basic medical knowledge; every day I waste my time repeating the treatment of insignificant diseases, which can be cured by having common household medicines" (2H, F, 32 years)
	c. Physicians fear taking risks with patients due to social pressure. Therefore, the patient's interest cannot be put first when physician safety is threatened.	
	d. The health insurance system makes it impossible for patients to have fair access to medical resources.	
Peers or teams (n = 23)	a. Professional misconduct or medical errors in peers are rarely	"In our typical medical practice, when facing peers' medical errors, we will always choose to cover up, because of the <i>big</i> environment. Once a small mistake in diagnosis and/or treatments is reported, the patient's family will take advantage

	reported to superiors.	of it, and the physician may have to pay, even as much as one hundred times the cost.” (3F, M, 31 years)
	b. Departments evade responsibilities.	
	c. Departments are only concerned about their own interests, causing inter-departmental conflicts.	
Institutions (n = 14)	a. Hospitals do not provide adequate protection for physicians, so they lack a sense of security	“The patient's family members did not accept the patient’s sudden death during his dialysis process, threatened the attending physician, and forced her to sign several legal documents to claim her responsibility, although she had none. However, the hospital security department did not provide aid to resolve the conflict, so the chaos lasted for five hours. This event caused the attending doctor severe psychological trauma and she had to receive one-week of psychiatric treatment.” (4D, M, 39 years)
	b. High volumes of patients cause physicians to overwork and burnout. Additional academic research pressure also adds excess stress.	
	c. The functions of smaller-scale primary hospitals are not fully utilized	
Education (n = 7)	a. Hospitals fail to provide appropriate training for physicians to improve their professionalism.	“When facing multiple patients in the ward, I have quite a few problems with communication with them and need a teacher to help me, but in reality, my superiors are too busy to help me solve my problems, unless they are related to technical medical aspects.” (1C, M, 29 years)
	b. Physicians do not seek additional education to update their knowledge and skills.	

Patients and their families (n = 41, 38%)

Doctors reflected that they were torn between commitment to honesty with patients versus adhering to cultural values and pressure from the patient's family members. Focus group discussions revealed that medical information and decision making are often conducted solely between the physician and family members, preventing patients from having individual informed consent when concerning terminal illnesses. Without the patient's knowledge, families may make life-saving or life-ending decisions on their behalf. They may also choose to not inform the patient of a fatal diagnosis.

"The patient's family did not want her to know her condition because they thought that the old lady would collapse if she knew that she had terminal cancer... I wanted to respect the wishes of the family, but... I'm not sure... because I... [could] not ask the patient if she wanted to know the truth, since either her son or her grandson was always there with her." (M, 35 years)

Within the theme of patients and families, another sub-theme that was reflected frequently by the participants was the challenge between patients' offensive behaviour that hinders the treatment process and the primary professionalism principle of patient welfare. Patients and their families often do not show respect towards physicians and profusely collect evidence during medical consultations and treatments.

"Once when I was performing an orthopaedic procedure, the patient's family members recorded and took photos of the whole process using their phones, which made me very uncomfortable. What made it worse was that they did not stop after I had asked them to." (F, 35 years)

"Some irritable patients will act up in the physician's office; some will even try to destroy public medical property and hurt us, and we cannot do anything about it." (F, 36 years)

Interview content frequently reflected the challenge between patients' distrust and irritability and patient management. Patients and their families often show distrust towards physicians' diagnoses and medical advice. With this perspective, the patient had become too irritable to accept the physicians' suggestions and was unable to communicate effectively.

"After my diagnosis, some patients went to see another physician to verify my judgment." (M, 33 years)

Society (n = 24, 22%)

Patients may view health care as a system in which money can buy guaranteed results, so they often misunderstand the limitations of health care professionals. The dissatisfaction with care may be a result of unrealistic expectations.

"The attitude of some patients towards healthcare workers is really rude. In the mind of the patient, health care is just a business deal between the physician and the patient." (M, 37 years)

Insurance policies and lack of coverage can also create challenges for physicians.

"The best course of treatment may not always be covered by public medical insurance." (F, 33 years)

Peers or teams (n = 23, 21%)

Peer assessment is a valuable source of information on physicians' professionalism [26]. However, some physicians decline to participate in peer assessment or are wary of participation. Based on reports from the focus groups, professional misconduct or medical errors among peers seem to be rarely reported to superiors due to concerns about whistleblowing during peer assessment or a lack of confidence in the effectiveness of peer assessment. Participants stated that they were worried that their assessments could negatively impact their relationships with their colleagues. Some junior attendings were afraid their unprofessional conduct may be exaggerated or may incur punishments, which also prevented them from reporting. This also reflects physicians' misunderstanding of unprofessional attitudes and medical ethics.

"... When facing peers' medical errors, we always choose to cover up ... Once a little mistake ... is reported, the patient's family will take advantage..., and the physician may have to pay..." (M, 31 years)

Patients with multiple complications often require interdisciplinary or multidisciplinary teams for diagnoses and treatments. Teamwork is, therefore, a fundamental factor in rehabilitation and an essential function of high-quality patient care [27]. However, in practice, departments are often only concerned about their own interests, which can cause inter-department conflicts.

"[When] encountering a patient with multiple complications, the departments that are involved often refuse to accept the patient and instead try to push the responsibility of the patient to one another." (F, 39 years)

"The quality of hospital consultations has severely declined. Different departments are only concerned about their own interests." (F, 42 years)

Institutions (n = 14, 13%)

Chinese hospitals are categorized into primary, secondary, and tertiary levels based on the scale of the institution and the level of expertise, with tertiary hospitals being more advanced and larger in scale [28]. More patients tend to gravitate towards tertiary hospitals, subsequently reducing the use of primary hospitals and wasting their medical resources while simultaneously posing a serious burden on tertiary hospitals.

"Regardless of the severity of the diseases, people will always go to tertiary hospitals. Primary (or community) hospitals are not fully utilized." (F, 42 years)

The recommendation to combine medical treatment with scientific research [29] led to physicians at tertiary hospitals being required to both continue their clinical practice as well as conduct academic research. All the interviewed physicians were from tertiary hospitals.

“Sometimes I treat more than 200 patients a day and have a variety of other intensive work, resulting in almost no time for my research.” (M, 33 years)

Education (n = 7, 6%)

Medical students face a plethora of practical clinical problems [30]. As a result of the lack of sufficient professionalism training in college, these problems become difficult to deal with in practice, and they need help [31].

“With lots of patients in the ward, I have lots of trouble communicating with each patient and need a supervisor to help me, but in reality, my superiors are too busy to solve problems unless it is regarding medical competency or clinical skills.” (M, 29 years)

Physicians’ actions in the face of challenges

The majority of respondents stated that physicians would take some actions when facing a professionalism challenge (n = 93, 85.3%). The most common types of action include direct verbal responses (n = 8), showing concerns for those who were wronged (n = 50), reporting incidences (n = 2), indirect verbal responses (n = 25), and bodily acts of resistance, such as leaving the room (n = 8; see Table 2 for more examples).

Discussion

Some countries have previously explored physicians’ professionalism challenges, including a qualitative study in Canada and a study in the UK that used online surveys to examine what students were witnessing or participating in the workplace [32]. Few studies, however, have focused on professionalism challenges in China, with the exception of one study that examines culture-related professionalism challenges at the National Taiwan University within the College of Medicine in Taiwan [33]. Therefore, the current study can fill some of the existing gaps in literature and can be used to compare to other countries physicians’ professionalism challenges with aims to solve the problem of professionalism challenges in China. According to the results of the current study, the discussion will include the causes of physicians’ professionalism challenges and methods of controlling the challenges mentioned.

Causes of challenges to physician professionalism

Previous research indicates that physicians experience professionalism challenges within their clinical practice. The current study confirms this and expands upon that notion by identifying five themes of professionalism challenge characteristics in clinical practice in China, namely patients and their families, society, peers or teams, institutions, and education. The current study suggests that patients and their families contributed the most to professionalism challenges in Chinese hospitals.

Seemingly, the patient’s family has absolute authority over patient care. Family members of patients can decide treatment plans for the patients without the consent of the patient and will also frequently monitor

the physician during the course of treatment. Therefore, in the treatment process, it is necessary to consider the involvement of family members. Multiple studies have examined the role of family members' participation in treatment [34-36]. A primary question that needs to be considered is how to address treatment decisions and procedures by combining the relationship between family members and patients with reality. Second, physicians are reluctant to adopt the most recent evidence-based treatment methods, partially due to society's incorrect assumptions of the physicians' profession, the current insurance system, and the lack of an effective personal security system for physicians. Relevant research on the aspects of reluctance has been conducted over the past several years and has led to successful improvements with developments and changes in society [37]. Third, there are flawed peer evaluation systems and institutional safeguards. They hinder physicians' self-awareness, teamwork skills, and the effective development of professional medical behaviour. The peer evaluation system has been examined in several countries, and research has been conducted in practice [38], but results have been difficult to promote in China. In the future, clinicians should be made fully aware of the peer evaluation system from an ideological perspective. Fourth, the classification of hospitals and the unequal distribution of medical resources have led to an inequitable use of medical resources. This causes physicians in some tertiary hospitals to be overburdened, which affects both physicians' clinical work and their scientific research. Fifth, the failure to conduct medical education in accordance with the actual needs of physicians has led to an inability to integrate theory and practice. In addition, interviewees from the current investigation infrequently referenced guidelines and policy documents. Ethical challenges are, according to the informants, primarily discussed during coffee breaks and in other informal situations. Inadequate education and a lack of a forum for discussing ethical challenges and experiences were most frequently reported in the focus groups. With time, these issues will likely impair the development of physicians' professionalism and may affect their future career development.

Controlling for challenges to physician professionalism

Based on the summary of the factors of professionalism challenges, we have proposed solutions to analyse the following problems. First, all of the physicians interviewed expressed experiences of challenges to professionalism, which showed that professionalism challenges may be widespread in China. Therefore, when health authorities and hospital managements design or reform medical education and health delivery systems, addressing challenges to physician professionalism challenges should be placed as a priority. Second, at the governmental level, it is important to guide society to an objective understanding of the roles and responsibilities of physicians and to improve hospital security systems, thereby providing a good environment for physicians to treat patients without the need to fear extraneous personal safety factors. Third, every hospital employee should be encouraged to report and prevent as many errors as possible so that patients can receive the best possible care from all providers [39]. In the opinion of the authors, one of the major components to reducing factors affecting physician professionalism is to quickly report these challenges to institutional authorities. However, it appears that very few Chinese physicians report challenges to their superiors and that physicians have an overall negative attitude towards reporting and remediating professionalism challenges. This calls for health authorities and hospital managers to provide practical solutions to these professionalism challenges.

These would include deepening the understanding of the scope and depth of challenges to physician professionalism and taking corresponding action by relevant departments to provide applicable training for Chinese physicians in the wake of these challenges. Fourth, physicians would benefit from receiving improved structural support and resources from health care organizations in order to promote physician professionalism. Successful professionalism regulation has been demonstrated to contribute to physicians' performance and well-being, influencing time spent listening to patients, reducing burnout, and increasing positive emotions [40]. Fifth, medical educators should help physicians construct emotionally articulate narratives to make sense of their experiences, actions, and identities and to better prepare them for future professionalism challenges. Formal curricula should also be refocused to reflect local needs. In this case, certain knowledge and skills related to commonly encountered professionalism challenges could be incorporated into the medical school or continuing medical education curriculum. Chinese medical schools could also consider allowing students to enter clinical clerkship earlier, in order to provide medical students with sufficient exposure before facing professionalism challenges in future practice.

Limitations

The current study has several limitations that we should note. The data were collected from only two institutions and the narratives were based on physicians' personal experiences. There is a need to further explore physicians' experiences in more diverse institutions and clerkships. Additionally, many novel ideas were brought up during the focus groups, which should be the subject of future research.

Conclusion

Currently, many developed countries have conducted preliminary studies on challenges to medical professionalism. However, there is a scarcity of this research in China. The current study analyses and summarizes factors to professionalism challenges in physicians' clinical work with the goal of providing reference for professionalism training and evaluation. The current study also provides broader ideas for alleviating the increasingly tense physician-patient relationship.

Declarations

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Abbreviations

ENT ear, nose and throat

Authors' contributions

DLW conceived this research and provided guidance and oversight for the project. HHL and WYZ conducted the focus groups. YTL, ND and WYZ analysed the data. YTL, ND, WYZ, and WWS all reviewed the data and analysis and participated in critical discussions. YTL drafted the manuscript. BW and XZ recruited participants for this study and contributed to the drafting of the manuscript. YTL, WYZ, ND, and HHL made significant contributions to the final draft, which all authors have approved. The authors have informed the journal that they agree that both YTL and WYZ made equal amounts of contributions typical of that of the first author.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

The ethical review board of the Academic Committee of China Medical University approved this study. We conducted this study according to the principles of the Declaration of Helsinki. Participants signed written informed consents and approved anonymous use of data after de-identification.

Consent for publication

Participants were made aware that anonymised quotes may be used in publications prior to giving consent.

Competing interests

The authors declare that they have no competing interests.

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