Professional Doctorate in Health Professions Education (DHPE)

Name of the Student: Usman Mahboob
Matriculation Number: 1001324

Title

How do medical students and clinical faculty members from two different cultures perceive professionalism?

School of Medicine
College of Medical, Veterinary and Life Sciences
University of Glasgow

Date handed in: 3rd February 2014

Declaration:

I hereby confirm that this work is my own, and that any legitimate collaboration, or reference has been properly indicated and acknowledged. This work has not been submitted for any other course or qualification on a previous occasion.

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Abstract

Background

Professionalism is contextual and varies with culture. It has multiple dimensions including individual, inter-personal, organizational, and societal components. The aim of this study was to add some new perspectives to understand professionalism. Professionalism was explored in the context of two different cultures, Scotland and Pakistan, to identify similarities and differences in perceptions of clinical faculty members and medical students.

Methodology

The method used was qualitative multiple case studies in a constructivist approach. Cultural Historical Activity Theory (CHAT) was used as a theoretical framework to enhance understanding of the study. Faculty members from three Scottish and three Pakistani medical schools were interviewed. Focus group discussions were arranged with groups of 7-10 medical students from each of the six medical schools. The data was analysed using a thematic analysis to identify reasons for cultural similarities and differences across two countries.

Results

The results were divided into nine themes, that is, the nature of the healthcare system, models and process of professionalism, attributes of professional doctors, approach of doctors towards their patients and other healthcare professionals, working in teams, self-regulation, the role of doctors in society and within families, dealing with ethical dilemmas and legally difficult situations, and resolving conflict situations in the work place.

Discussion

The variance of professionalism found in this study was mainly due to the health professionals working in two different healthcare systems. The cultural differences between the two countries were reflected in these systems and the activity of professionalism included conflicts and dilemmas, self-regulation, and professional

attributes. Medical professionals were found to adopt different institutional models of professionalism when they perform their daily activities.

Conclusions

This study showed that doctors and medical students from both countries have mostly similar perceptions about professionalism with some dissimilarities resulting from differences in the culture, history, institutional ethos, daily activities and the role of religion. There is a lack of training in professionalism and a need to include it in the formal curriculum in Pakistan. A training programme could be organized and incorporated into the curriculum using the themes, models and process of professionalism with attention to culturally sensitive situations to prepare medical students for their early professional years in both countries. A focus needs to be on the preparation of communication skills in different contexts and the improvement of the internal environment, which is within the control of every individual. A faculty development programme, with similar objectives, needs to be introduced for medical staff to enhance their understanding of professionalism.

Acknowledgement

I am highly indebted to my supervisors, Phillip Evans, Philip Cotton, and Nicki Hedge for their indomitable support and valuable guidance, and for taking time out from their busy schedule showing remarkable patience at every stage and to oversee my Thesis. I would like to express my deep gratitude for their persistent help, not only in the completion of my Thesis but also ensuring the quality of my study.

I am extremely grateful to all the study participants who took time out of their engagements and shared their knowledge about the topic of professionalism. Moreover, I am highly obliged to all the Deans/Principals and the focal faculty members of the medical schools/colleges who allowed me to carry out my research work in their medical schools/colleges in a most congenial atmosphere.

The unwavering financial and phenomenal moral support extended by Prof. (Dr) Hafeez Ullah in the capacity of Vice Chancellor, Khyber Medical University, Peshawar, Pakistan, has been a great source of strength, encouragement and inspiration, which only made it possible for me to complete my Doctorate at a world class University.

I am thankful to the School of Medicine and the Library of the University of Glasgow for helping me in facilitating and providing me with all the relevant documents and articles and pertinent writing material for consultation.

The constant inspirational advice and extraordinary moral support and relentless backing and encouragements by my family members, friends, and colleagues at every moment during these two years, have been the strong motivational force behind the completion of my Doctorate in Health Professions Education.

I hope that any reader will benefit from reading this research work.

Dr Usman Mahboob

List of abbreviations

ACGME	Accreditation Council for Graduate Medical Education
AT	Activity Theory (synonymously used for CHAT; Cultural Historical Activity Theory)
CA	Content Analysis
CAS	Complex Adaptive System
CanMEDS	Canadian Medical Education Directives for Specialists
CCU	Cardiac Care Unit
CHAT	Cultural Historical Activity Theory (synonymously used for AT; Activity Theory)
FGD/FGDs	Focus Group Discussion/s
GP/GPs	General Practitioner/s
GMC	General Medical Council
ICU	Intensive Care Unit
NHS	National Health Services
OPD/OPDs	Out Patient Department/s
OT/OTs	Operation Theatre/s
PMDC	Pakistan Medical & Dental Council
RCP	Royal College of Physicians
SDMCG	Scottish Deans Medical Curriculum Group
SR	Self-Regulation
SSI/SSIs	Semi Structured Interview/s
TA	Thematic Analysis
TRIAD	Triage Rapid Initial Assessment by Doctor

List of operational definitions

Activity Theory/ Cultural Historical Activity Theory

A specific form of societal existence of humans consisting of purposeful changing of natural and social reality (1).

Competence

What individuals know or are able to do in terms of knowledge, skills, and attitude (2).

An ability to perform under controlled conditions – like simulation.

Capability

The extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance in real life situations (2).

Complex Adaptive System (CAS)

A dynamic, non-linear system which involves rich interactions between agents, with multiple feedbacks loops, and operated by a set of rules that changes over time, through encounters with the environment, and with each other. The agents in the healthcare setting are doctors, patients, public, and other stakeholders. The study of complexity involves how order emerges from the interaction of the agents, and has an historical element to it (3).

Process of Professionalism

Professionalism is the management of limitations, conflicts and dilemmas through self-regulation and guidance.

Self-Regulation

Self-regulation in health professionals is the process used to regulate ourselves in order to treat others appropriately.

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Chapter 1

Introduction

Chapter 1: Introduction

Key points

Professionalism is:

- considered as a core competency in today's medical world.
- contextual and varies with culture and the different roles of a doctor.
- how well a doctor can manage his/her internal and external conflicts.
- About a framework of actions based on self-regulation.
- influenced by the national culture and healthcare system.

Introduction

Professionalism in medical practice is a global issue. However, a global or universal definition or corpus of understanding has not yet emerged (4). Such a definition is difficult to establish for a number of reasons, which include:

- The contextual nature of professionalism.
- Its dynamic nature due to personal, interactional, and institutional dimensions.
- Variance within and between national norms.
- Variance in cultural influences and values.
- A lack of a common international forum in which the issues can be discussed.
- The learning of professionalism mainly through the informal and hidden curriculum.
- Complexity due to subjectivity of the topic.

An explicit discussion and research on professionalism is necessary because of the changing landscape of healthcare and society (5). Medical education is no longer about curriculum and professional development but extends to addressing personal development, as the moral values in society also influence the medical professional (5). The focus on developing professionalism intends to develop an identity of a doctor as a professional and as a person (6). These identities are constructed, and co-constructed all the time by the interactions within the community of practice,

changing norms and culture of society and hence, it is not static but dynamic (6). Clarifying the global identity of a doctor is important for the following reasons.

- The conflicting roles such as clinician and educator, facilitator and assessor.
- Balancing and delineating between personal and professional life.
- Cultural variations such as language and interactions.
- Means for internal and external regulation.
- Enforcing professional values and goals.
- Understanding the power dynamics, associated with different roles.
- Improving inter-professional teamwork and performance.
- Developing trust and confidence of students, patients and other stakeholders in their professional abilities.

Professionalism as a concept has evolved in the last 100 years but the focus on it has increased in the past 15-20 years (7). Significant attention has been given in recent years to the question of professionalism in medical education and practice. While this attention has been productive, there is no common understanding of what is meant by medical professionalism (8). Accordingly, many of the discussions have not been very clear because the word professionalism carries with it so many implications and complexities (8). Different groups have used the word in their own way and for different reasons(8). However, for the ideal of professionalism to survive, medical professionals need to understand its role in the social contract (9). They have to meet the obligations necessary to sustain professionalism and ensure that healthcare systems and society support the behaviour that is compatible with professional values (9). The 'social contract' changes from one culture to another for example, a social contract in Scotland and in Pakistan are different. Moreover, it is necessary to understand clearly what medical professionalism means and requires if professionalism has to remain central to medical education and medical practice (8). Therefore, the current focus on professionalism may result in a positive change that benefits both the profession of medicine and the society, it serves (8).

Professionalism is about balancing expectations to reach an optimum, managing both external and internal environment. Due to the contextual nature of professionalism, this balance can at times become difficult and may lead to

limitations or a conflict (10). Hence professionalism in a broader sense is, how well a doctor can manage limitations and conflicts (which can be internal and external), towards patients, students, colleagues, family, organization, system, and broader society. The better the balance, the better a person will be considered a 'professional'.

Professionalism is taught differently through each stage of training. It is known to be delivered mostly through the informal curriculum, and role modelling but efforts are made to teach it explicitly (11, 12). At undergraduate level, it is taught formally through the medical curriculum. At postgraduate level, in the UK, the regulatory body aim to promote it through external imposition of self-regulation for example, appraisal and revalidation (13).

The concept of self-regulation provides a framework in which a doctor behaves and acts in a professional manner (14). Self-regulation in the literature refers to the management of ones' responses in order to pursue goals and live up to standards (15). It has also been defined as '*self-generated thoughts, feelings, and actions that are planned and cyclically adapted to the attainment of personal goals*' (16). Self-regulation, as a concept is mostly considered as improving the 'self' and the internal environment. After a detailed analysis of self-regulation and comparing it to professionalism, I have operationally defined it as: Self-regulation in health professionals is the process used to regulate ourselves in order to treat others appropriately. The difference in this definition and the usual understanding of self-regulation is in the second part, where the reader will appreciate that, through self-regulation, we improve ourselves for the sake of others, and not for our own personal gains. Even the increase in knowledge is for the better treatment of patients. Though, it has a reward in its own right in career progression, but the priority here is patients, while climbing the ladder in a professional role is a bonus.

The role of a doctor as a 'healer' is universal to all cultures and societies but there are local differences in professionalism due to the different roles, that a doctor plays in his/her daily routine. This emphasises the fact, that there are national and cultural differences in both social contract and professionalism (17). The culture of professionalism varies at micro, meso and macro levels. For example, at micro level, there may be differences in approach towards patient between two doctors

in a same ward. The meso and macro level differences may be observed at institutional and societal level.

The healthcare system of a country reflects the national culture of society and the practices of professionalism within that culture (17, 18). Such differences have been previously observed between the Western and Eastern cultures with help of Hofstedes' Culture Dimension Theory (19, 20). The differences, predominantly, were due to the social structure of society for example, collectivist Asian culture versus individualistic Western societies. The Asian doctors were more focused on professional attributes such as, altruism, confidence, punctuality, discipline, hierarchies, and adaptability whereas the Western doctors regarded patient safety, teaching, and collegiality as important professional attributes (19). However, it does not mean that one is better than another but reflects on the social contract of a doctor with society. The professional attributes which are demanded by society are focused more by the doctors living in that vicinity (17, 21).

Rationale of the study

The World Federation for Medical Education has set up criteria for global competencies for undergraduate medical education (22). These criteria provide a general framework for professionalism. However, professionalism as a topic is contextual and varies with culture. It has multiple dimensions such as individual, inter-personal, organizational and societal (23). This implies that although we can set some core criteria for professionalism which can be generic but those generic criteria needs to be adjusted according to the local needs. Different versions of a doctors' professionalism are influenced by the everyday aspects of their work and one version may not necessarily be more professional than the other (24).

The GMC and Scottish Doctors have also identified professionalism as a core competency for medical professionals (25, 26). However, the lack of an agreed definition makes its teaching and assessment difficult to integrate into the curriculum. The definition may have to be modified in different settings and according to local requirements of institutes, but there need to be core elements in all these definitions such as excellence, humanism, accountability and altruism (27). The topic has been defined by several organizations and individuals, from

simple definitions, to a range of principles, domains and dimensions (8, 23, 28-32). All these definitions considered various criteria which were tested in a recent study by Madawa *et al*, but the survey only questioned faculty members (19). Moreover, the survey was unable to identify the reasoning behind the cultural differences in prioritizing the criteria for professionalism (19). A separate study, between students from Taiwan and Canada, compared students' reasoning behind professional dilemmas and found dissimilarity due to differences in Confucian and Western culture (33). The limitation of this study was that it was based on interpretation of video tapes which were actually made for Canadian students, thus complicating the fact that the Taiwanese students were commenting on Western values and on cultural differences outside their own professional context (33). Their reflections on the videos and their beliefs may not be what they practice, thus further confusing the situation, whether they took it as professionalism or unprofessional practice (33). Moreover, the literature suggests that a comparative dimension is required to study professionalism whereby different contexts of medical education may be studied to know the similarities and differences between different groups of health professionals (34).

This study addressed the limitations of the previous two studies by engaging three medical schools from a developed Western country (Scotland) and three medical schools from a developing Eastern country (Pakistan). This was a qualitative study using multiple case studies technique designed to enhance the understanding from study findings with help of the theoretical framework of Cultural Historical Activity Theory (CHAT). Both students' and faculty members' views were gathered and triangulated with each other.

In this study, professionalism has been studied in the context of two different cultures, so as to identify similarities and differences between the two cultures. One rationale of this study is to add new perspectives to the international generic criteria of professionalism. These new perspectives may provide a framework to curriculum managers for evaluation of their teaching and learning of professionalism in medical schools.

Research questions

The research questions in this study were influenced by the recommendations of a previous quantitative study on professionalism that failed to capture the reasoning in understanding professionalism because of the lack of a qualitative analysis (19). Initially, I planned a quantitative study but once Madawa *et al* (19) published their study, I felt that it would be a repetition and add nothing new to the literature. Therefore, I modified my study and developed four new questions based on the recommendations of previous research. The questions are as follows:

Q 1. How do cultural differences affect the professionalism of doctors?
Q 2. How do medical students from different cultures perceive professionalism?
Q 3. What are the cultural similarities and differences in understanding professionalism, within a country?
Q 4. What are the cultural similarities and differences in understanding professionalism across cultures?

Culture has been recognized as a contextual factor in understanding professional dilemmas and attributes (35). Culture is influenced by history and activity, while looking at it from the model of the Cultural Historical Activity Theory (1). In this study, the history and activity of Scotland and Pakistan are mainly influenced by four factors namely, economics, politics, social, and religious factors. This includes the influences by economics (poor versus rich healthcare system), politics (fair versus corrupt regulators), social dimensions (community, polite versus strict, rigid views versus tolerant views, polarized versus non-polarized, more educated versus less educated, protocol versus non-protocol culture, privileged versus non privileged, strong organized healthcare system versus weak disorganized, imbalanced proportion of private and public sector),and religion or spirituality (welfare state versus republic state) (35).

The exploration of the topic with help of a socio-cultural theory, Cultural Historical Activity Theory (CHAT) will enhance an understanding of a study findings which may help to improve care of patients (1, 35, 36). A multiple case study technique was used as a methodology to gather evidence for this study. A single ‘case’ was ‘one medical school with its affiliated teaching hospitals’. The study included three

medical schools from Scotland and three from Pakistan. This complementary research from two different geographical areas in the context of religion, such as a secular (humanistic) model in Scotland and an Islamic model in Pakistan brought forth additional perspectives (35). The focus in this study was on the case, not an individual, to gain an holistic picture of the situation in these geographical areas (36).

The faculty has a responsibility to develop an understanding of professionalism of students and to guide them in how to handle complex medical situation while also keeping in view norms of society (33). This may be done by introducing professionalism in the explicit curriculum (5). However, the role of the informal curriculum in developing professionalism is more influential than the formal curriculum (11). Hence, a culture of professionalism may be promoted so that students may observe what they are taught in the formal curriculum. The question also intends to address some social factors, such as, the interactions and power dynamics between students and teachers.

The keywords for criteria of medical professionalism were identified from the selected literature, such as Tomorrows' Doctors, Good Medical Practice, and two recent papers on professionalism (19, 37-39). Thirty five categories of professionalism were identified from the literature, and were organized under nine themes. A total of sixteen questions were developed to get in-depth views of study participants on these nine themes. The questions were pilot tested through semi-structured interviews with three faculty members of health professions education from two universities in Scotland. Table 1 shows a set of questions that were asked from the study participants.

Table 1: Set of questions for interviews and focus groups

1. Can you describe what professionalism means to you in the context of a doctor?
2. How do you think a professional doctor should approach his patients? (or relatives or carers of his patients).
3. What is the usual practice that you observe when doctors communicate with patients? Is the practice the same as you expect? (Any example?).
4. What is your experience of the doctors when you were a patient? Was it the same as you would expect from a professional doctor? (Any example?).
5. How do you find doctors, when dealing with their colleagues/trainees?
6. How do they act in teams in their clinical settings?
7. How do doctors treat other health care professionals? (For example, a nurse, dentist or a homeopathic doctor, etc.).
8. Do you think doctors should regulate themselves to improve professionally? If yes, how should they do it?
9. How do you self-regulate yourself to be a professional doctor?
10. Do you think, other doctors actually self-regulate in reality? What are the usual practices which you observe?
11. What are your views on how society regards you as a doctor/or medical student? What are their expectations of you?
12. What are your views on how your family regards you as a doctor/or medical student? What are their expectations of you? (e.g. giving medical advice to family).
13. What are the difficulties/stress that this creates for you? Can you give an example?
14. How often do you think, the doctors work within their defined professional limits and legal boundaries?
15. Have you ever felt a conflict between practising medicine and the law?
16. How do doctors resolve issues and difficult situations which may arise in their work? (For e.g. ethical situations related to patients, students, colleagues or teams and system or administration).

Study setting

The study was carried out in Scotland and Pakistan. Two groups, clinical faculty members and medical students from three Scottish medical schools, were compared with three Pakistani medical schools. Both countries have different geographical locations, histories, and culture. Scotland is an economically developed country as compared with Pakistan. The culture of Pakistan is more conservative compared with Scotland and there is a remarkable difference in population to resource ratio. Scotland has a more balanced population to resource ratio whereas Pakistan's population exceeds its resources (40). Pakistan's economy, social and healthcare system is also greatly influenced by the war in neighbouring Afghanistan. The regulatory bodies, GMC and PMDC (Pakistan Medical & Dental Council) function differently. The GMC has a balanced representation of different stakeholders. However, the PMDC has an imbalanced representation from public versus private sector medical schools, doctors versus non-doctors, and is politically influenced.

In Pakistan, a doctors' professional judgement is influenced by the pressure from a large number of patients. The unofficial estimate of doctor to patient ratio in Pakistan is 1:1280 (41), whereas in Scotland it is around 1:100 (42). This means less consultation time for Pakistani patients. In the UK, the consultation time varies between 10-15 minutes for one patient however in Pakistan; it may be around 2-3 minutes. The doctors in Pakistan have less time to establish a rapport with the patient and thus, less patient satisfaction.

Another external factor is the difference in remuneration. In the UK, the average pay of a consultant doctor (£100,000/annum or Rs.15 million/annum, in 2013) is 7.5 times more than the Pakistani doctor (£13, 333.33 or Rs.2 million/annum) (43). Due to the relatively low remunerations, the Pakistani doctors run their own private clinics in the evening, where professional judgement is at 'high stakes' and the reputation of doctors is at risk.

Specific Medical Schools

The first case in this study is one of the largest medical schools in Scotland and the students are dispersed over twenty hospitals. A focus group session was arranged with 7 students from Year 4 (5 male and 2 female). The group included six Scottish students and one male student from Singapore. The faculty members were senior clinicians from General Practice, Medicine, Communication Skills, and ENT. Five clinical faculty members were interviewed, including one female clinician from General Practice.

The second case was a medical school from East of Scotland. Five clinical faculty members were interviewed. They were senior clinicians from Clinical Skills Centre, Oncology, Cardiology, Medicine, and General Practice. A focus group session was arranged with 7 students from Year 4 (1 male and 6 female). All students in the FGD were from Scotland.

The third case was a medical school from the Northern part of Scotland, where 5 clinical faculty members were interviewed. These faculty members were senior clinicians from Communication skills, Surgery, Medicine, and Endocrinology. A focus group session was arranged with 9 students from Year 3 (4 male and 5 female). The

students from Year 4 were not available because of examination. The students in the FGD were from different ethnic origins such as, USA, UK, Middle East, and Singapore.

The fourth case was a public sector medical school from Khyber Pakhtunkhwa (KP) province, Pakistan. Nine clinical faculty members were interviewed. The faculty members were from disciplines of Surgery, Dermatology, Psychiatry, ENT, Oncology, Microbiology, and a female doctor from Endocrinology. A focus group session was arranged with 8 students from Year 4 (4 male and 4 female). All the students in the FGD were local students from KP Province, Pakistan.

The fifth case was a private sector medical school from Khyber Pakhtunkhwa (KP) province, Pakistan. This school has strong Islamic religious values, and the main form of teachings of professionalism is through the informal curriculum. The medical school has also introduced its own book, based on Islamic values for a professional doctor (44). The book-project was investigated by a group of Islamic and Ethics scholars. It was edited by clinicians for relevance and an English expert for translation and explanation of the different Islamic quotes, which were in Arabic, not commonly understood in Pakistan. The quotes from the book were matched with evidence from the literature on professionalism and ethics. Six clinical faculty members were interviewed who were from clinical disciplines of Gastroenterology, General Practice, ENT, Surgery, Medicine, and a female clinician from Paediatrics. A focus group session was arranged with 10 students from Year 4 (5 male and 5 female). All students in the FGD were natives from KP Province, Pakistan.

The sixth case was a private sector medical school from Rawalpindi city, Pakistan. This city is in the Punjab province, over 100 miles away from Peshawar. Professionalism is mainly experienced through the informal curriculum. Six clinical faculty members, two females and four males, were interviewed from Surgery, ENT, Urology, and Gynaecology & Obstetrics. A focus group session was arranged with 10 students from Year 4 (5 male and 5 female), who were from Punjab and KP Provinces of Pakistan.

Ethics approval

Ethics approval was necessary under the Helsinki agreement. The study had to be properly conducted out of respect for the students and staff members who gave their time to this study. The study was ethically approved by the Medical, Veterinary and Life Sciences (MVLS) College Ethics Committee, University of Glasgow on 25 October, 2012. A letter from the ethics committee is attached in the appendix 5.

Chapter 2

Literature Review

Chapter 2: Literature review

Key points

- Professionalism is multi-dimensional and requires a multi-paradigmatic approach in order to understand it.
- There are differences between traditional and new views of professionalism.
- The three primary academic areas of literature on professionalism are from sociology, medicine and education.
- The topic has been defined by several organizations and individuals.
- Professionalism is associated with many themes in the literature such as ethics, self-regulation, identity, power, curriculum, and assessment.

Protocol for the Literature Search

The literature was searched with reference to the protocol suggested by Haig and Dozier (45, 46). The literature for the study was searched through three techniques that is, databases, search engine, and hand search. The protocol for databases and search engine maximises the effectiveness of searching collections of electronic journals. More specifically the steps are:

- Establish the field and scope, and clarify the title.
- Expand the title using synonyms and keywords.
- Apply the search to databases and search engines, using Boolean commands to moderate the results.
- Establish inclusion and exclusion criteria.

Field and the scope: The initial literature search on professionalism revealed its individual, inter-personal, institutional, and cultural dimensions, shown in Figure 1 (23). The area which was least explored in the literature was the 'cultural dimension' of medical professionalism hence it became the focus of this study (35). Figure 2 shows the literature search strategy for culture of medical professionalism.

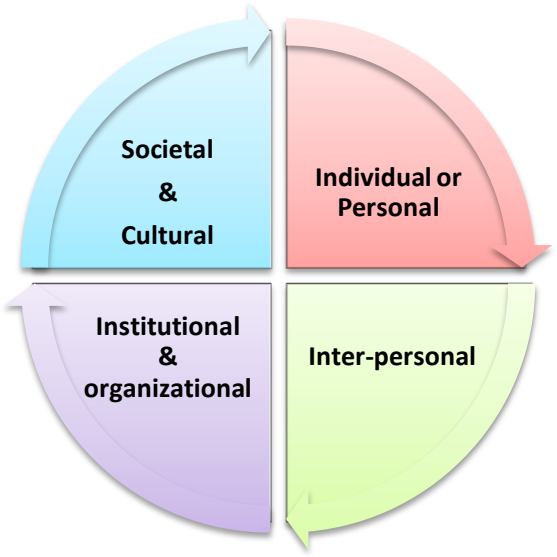


Figure 1: Domains of professionalism: multi-dimensional approach. Original diagram, compiled from information in Hodges *et al* (23).

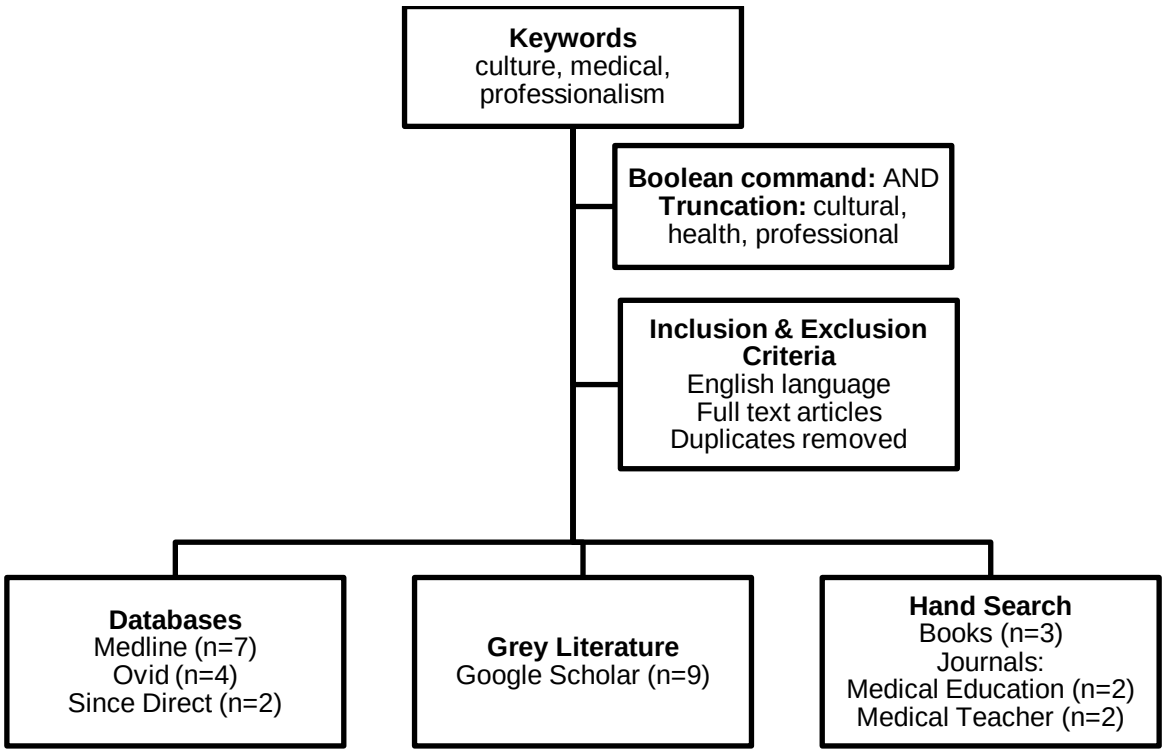


Figure 2: Literature search strategy for culture of medical professionalism.

Keywords in the title: The keywords used in the initial search were: culture, medical, and professionalism. The method of truncation was used for the variation of keywords such as, health, cultural, and professional. The words were initially searched separately and then combined by the Boolean command 'AND' to get the combined search. Further searches were done exploring different key areas of

professionalism such as, definitions, curriculum, assessment, ethics, self-regulation, power, and identity. The synonyms for some words such as, 'examination' instead of 'assessment' were also used with the three main words, that is, culture, medical, and professionalism.

Databases and Search Engine: The databases searched were Medline, Ovid and Science Direct, whereas the search engine used for the grey literature was Google Scholar. The search for 'culture AND medical AND professionalism' lead to 7 full text articles from Medline, 4 from Ovid, 2 from Science Direct, and 9 from Google Scholar.

Inclusion and exclusion criteria: The titles and abstracts which were having the keywords and were relevant to the study were selected. The limits used were 'full text' and 'English language' to exclude other languages and those articles whose full text were not available through databases. The search was further refined by removing duplicates. An example of a search strategy for Ovid database is shown in Table 2.

Table 2: Search results from Ovid database.
AND (Boolean command), * (Sign for truncation)

Searches	Results	Number of articles	Search Type
1	medical	595848	Advanced
2	culture	195646	Advanced
3	professionalism	6223	Advanced
4	(culture* AND medical AND professionalism*)	18	Advanced
5	limit 4 to English language	18	Advanced
6	limit 5 to full text	10	Advanced
7	remove duplicates from 6	4	Advanced

Hand Search: The hand search included both books and journals. The books included Measuring medical professionalism, Understanding medical education, and a practical guide for medical teachers. The journals included in hand search were Medical Education and Medical Teacher.

The three primary academic areas of literature on professionalism were from sociology, medicine and education. The fundamental issue of the sociology literature was the nature of social control in the modern society (4). The issues from medical literature were more about self-identity and social status (4). The education literature is an important source of writings on the "new professionalism" such as, reflection, mindfulness, patient-centredness, and inner apprentice (47-49). The topic has been widely discussed by individual academicians through peer review papers and by the health regulatory bodies through policy documents. The literature review follows the concept of how professionalism evolved. It is divided into different parts based on the literature available from the individual academicians, the health regulatory bodies from different countries, and the emergence of themes associated with culture of professionalism. The themes identified from the initial literature search are given below.

- Influence of culture on professionalism
- Definitions by regulatory bodies and organizations
- Definitions by individual academicians
- Influence of healthcare system on professionalism of doctors
- Sociology and professionalism
- Ethics and professionalism
- Self-regulation and professionalism
- Professionalism and identity formation
- Professionalism and power (dynamics)
- Curricula and professionalism
- Measurement of professionalism

Influence of culture on professionalism

Culture is defined as the dynamic and multi-dimensional context of many aspects of the life of an individual (50). It includes gender, faith, sexual orientation, profession, age, socioeconomic status, disability, ethnicity, and race (50). Culture is composition of an integrated pattern of learned beliefs and behaviours that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views of roles and relationships, values, practices, and customs (51).

Health professionals show diversity, as patients present varied perspectives, values, beliefs, and behaviours regarding health and well-being (51). Culture influences patients' attitude and behaviours based on their values and beliefs (51). These include variations in patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a doctor who understands their meaning, ability to understand the prescribed management strategy, expectations of care, and adherence to preventive measures and medications (51). Failure to understand sociocultural factors may lead to stereotyping and biases or discrimination in treatment of patients based on their race, culture, language proficiency, or social status (51, 52).

The culture of professionalism has evolved over time by a process of exploration and reflection (53). Medical professionalism has changed from paternalism to partnership with patients and mutuality, from tribalism to collegiality, and from self-sacrifice to shared responsibility (53). There are different barriers to practicing professionalism for example, time constraints, workload, and difficulties interacting with challenging patients (54). However, despite these difficulties, healthcare organizations strive for excellence by developing a culture of professionalism (55). The organizational culture influences the individual health professionals (55). For example, doctors occasionally staying in a hospital in order to complete patient care tasks even when, according to the clock, they are required to leave, because their organizational culture stresses performing work thoroughly (55). The culture of professionalism is also influenced by many personal and environmental factors (56). Personal factors include distress/well-being, individual characteristics, and interpersonal qualities (56). The environmental factors include institutional culture, formal and informal curricula, and practice characteristics (56). An understanding of these factors may allow the development of more effective approaches to promote physician professionalism. (56).

It is important to understand professionalism in its cultural context for three major reasons (51). First, to prepare health professionals to meet the health needs of growing, diverse population (51). Second, cross-cultural education can improve patient-doctor communication (51). Third, accreditation bodies for medical training now have standards that require cross-cultural education as part of

undergraduate medical education (51). Many medical schools are now engaging in curriculum renewal, and transforming the formal curriculum itself may provide another pathway or intervention for changing institutional culture in ways that promote professionalism (57). The aim of a culture sensitive curriculum is to promote moral, ethical, altruistic, and humanistic values (58). The goal of these curricula is to prepare students to care for patients from diverse social and cultural backgrounds, and to recognize and appropriately address racial, cultural, and gender biases in health care delivery (51). Different strategies have been implemented to develop a culture of professionalism in a medical school such as, integrating medical ethics, public health, legal medicine, and the history of medicine in a curricular theme for professionalism (58).

The training in cross-cultural medicine focuses on domains of knowledge, skills, and behaviours (57). Each component plays a crucial role in training students. Improvement in behaviours and attitudes can be brought by promoting reflective exercises to understand ones' cultural biases, tendency to stereotype, and appreciation for diverse health values, beliefs, and behaviours (51, 59). From a practical perspective, efforts to change attitudes are labour-intensive, difficult, and complex to evaluate, and can seem abstract to those who are more clinically oriented (particularly medical students in their clinical years, and residents). However, attitudes such as curiosity, empathy, respect, and humility are critical to effective communication in the medical encounter, whether the patient is from a similar or different cultural background (51). The focus of knowledge component is community-oriented on specific, evidence-based factors (51, 57). The health professionals have to be aware of the cultural norms of their patients for its impact on their health, and the treatment choices that are available in those specific situations (51). For example, common cultural and spiritual practices that might interfere with prescribed therapies such as Ramadan observance, the pre-dawn to sunset Fast practiced by Muslims, and how this might affect diabetics (51).

The focus of skills component involves development of communication skills (51). The aim is to train health professionals to be aware of certain cross-cultural issues, social issues, and health beliefs while translating them to clinical information (51). The health professionals identify and negotiate different styles of communication,

assess decision-making preferences, and the role of family (51). Moreover, the communication includes gathering information to determine each patient's perception of biomedicine and complementary and alternative medicine, recognition of sexual and gender issues, and to be aware of issues of mistrust, prejudice, and racism (51).

One of the reasons for culture change to be challenging is because of an evolutionary construct known as the negativity bias (60). The negativity bias drives people to be affected by the negative aspects of experience, and influences their cultural beliefs and values (60). Some common teaching methods such as, simulations, and instructions in clinical reasoning inadvertently reinforce the negativity bias and thereby enhance health professional focus on the negative (60). However, positive psychology is a powerful tool to counteract the negativity bias and aid in achieving desired culture change (60). Positive psychology asserts that day-to-day emotional experiences affect the very course of people's lives (61). By deliberately noticing positive emotions and experiences, individuals have the opportunity to fundamentally change how they perceive their environment, how they think, and how they act (61). In comparison with negative emotions that narrow peoples' ideas about possible actions, positive emotions broaden their ideas (62). This may not require a lot of effort and simple, sincere positivity used commonly, but not excessively, could be the spark for culture change in medical education (60). Thanking a colleague for his or her advice, or listening to a student or a patient who has had a difficult experience may have lasting effects that extend beyond their intended meaning (60, 62).

Definitions by regulatory bodies and organizations

The Accreditation Council for Graduate Medical Education (ACGME) have set six general competencies for doctors, and professionalism is one of them (29). They have written protocols on how to behave and act like a professional doctor (63). They have identified '360 degree' and 'checklist' as instruments for its assessment (29) but have not defined professionalism in their list of glossary of terms (64). The criteria which they have established for doctors to achieve professionalism as a competency are many, such as professional responsibilities, adherence to ethical principles, assurance of safety and welfare of patients, provision of family-centred

care, better time management, care for own health and for the health of the peers, zeal for lifelong learning, honesty, and altruism (63). This suggests that setting protocols for professionalism and recognition of assessment instruments for it are easier than defining it (4). This can lead to a counter argument on how one can set protocols and assessment instruments without properly defining a term (4). The protocols have been set according to the context of the American culture (4). However, the word 'altruism' may not be as applicable and as widely used in the UK culture which mainly uses the 'patient centred' approach (4). This endorses the argument of Wagner *et al* that the definitions of professionalism obscures their meaning when applied to a specific context, that is, professionalism varies as the context changes (65).

The same year when professionalism was listed as ACGME general competency, the Medical Professionalism Project was launched by American Board of Internal Medicine (ABIM), the American College of Physicians Foundation, and the European Federation of Internal Medicine (4). The project developed a physician charter for medical professionalism for the new millennium (28). It set forth three fundamental principles for medical professionalism (28). The first principle was the primacy of patient welfare and patient-doctor relationship and was based on altruistic behaviour of the doctor towards their patients (28). The second principle was constructed around the autonomy of the patients, their empowerment about the decisions related to their health as long as it is within the ethical practice, and honesty of the doctors with their patients (28). The third principle founded ground on social justice that doctors need to promote fairness and justice in the distribution of health care resources without any prejudices of race, ethnicity, gender, socioeconomic status, religion or any other social group (28). These principles, however, are not a definition (4). The project also developed a set of ten professional responsibilities given in Table 3.

Table 3: List of professional responsibilities.
Redrawn from the charter on medical professionalism (28).

1. Commitment to professional competence.
2. Commitment to honesty with patients.
3. Commitment to patient confidentiality.
4. Commitment to maintaining appropriate relations with patients.
5. Commitment to improving quality of care.
6. Commitment to improving access to care.
7. Commitment to a just distribution of finite resources.
8. Commitment to scientific knowledge.
9. Commitment to maintaining trust by managing conflicts of interest.
10. Commitment to professional responsibilities.

The third principle was criticized by other organizations (66). It was suggested that physicians can take these important principles and can apply them to the depth required in their local contextual situation (66). The project also identified this limitations that, although medical professionalism shares some common generic attributes because of the role of physicians as healers, there can be some cultural and national variations (28). These variations in medical practice and delivery across cultures can lead to complex and subtle interpretation of these general principles (28).

The National Board of Medical Examiners (NBME) jointly arranged a conference on professionalism with Association of American Medical Colleges (AAMC), in 2002. They published a report which arranged observable behaviours according to the categories that could clarify professionalism, shown in Table 4 (67).

Table 4: Template for categories of professionalism.
Modified from NBME (67).

Category	Might Also Include
1. Altruism	
2. Honour and Integrity	Honesty.
3. Caring and Compassion	Sensitivity, tolerance, openness, communication.
4. Respect	Respect for patient's dignity and autonomy, respect for other health care professionals and staff including teamwork, relationship building.
5. Responsibility	Autonomy, self-evaluation, motivation, insight.
6. Accountability	Commitment, dedication, duty, legal/policy compliance, self-regulation, service, timeliness, work ethic.
7. Excellence and Scholarship	
8. Leadership	Management, mentoring.

The objective of the conference was not to define professionalism but to establish a platform for the assessment of professionalism by identifying the observable behaviours (4). Nevertheless, it identified the criteria that can be helpful in defining professionalism. The organization has recently launched a programme on Assessment of Professional Behaviours (APB) (68). Their instrument consists of a multisource feedback evaluation form for raters, and a self-evaluation form for individuals being assessed (68). The form consists of 23 behavioural items rated on a frequency scale to give feedback to trainees on professional areas that need further improvement (69).

The Association of American Medical Colleges (AAMC) and the American Medical Association (AMA) have been involved indirectly in reforming professionalism for 21st century through their renowned journals 'Academic Medicine' and 'Journal of American Medical Association' (JAMA), respectively (4). These journals have been a rich source for the available literature on medical professionalism (4). The literature spans from definitions of professionalism (8) to instillation in medical education (70), its teaching and modes of delivery (71), mindful practice (47) and role of self-reflection (72), faculty development for teaching of professionalism (73, 74), charity and professionalism (75, 76), quality of care and professionalism (77, 78), de-professionalization (79), humanism consciousness (80, 81), professional behaviours (82) and system views (83), distinction between narrative and rule-based professionalism (84), its measurement and assessment (85-87), development of environments and culture of professionalism (88, 89) up to the problems (90) and complexities around the topic of professionalism (91).

The main regulating body for the medical professionals in the UK is the General Medical Council (GMC). The GMC, in their official document 'Good Medical Practice' (39), describes good doctors as follows:

> "Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up-to-date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity."

Some of the practitioners may take this as a definition of professionalism to self-regulate and may consider it as sufficient enough to act and behave like a good doctor. However, others may differ, as it is not a written definition of

professionalism. The strength of this definition is that it encompasses both the personal values of a doctor such as honesty, integrity, caring, trustworthiness, and an endeavour for a continuous improvement. It also covers the relations with the people they deal in their professional life such as patients and colleagues.

The Royal College of Physicians (RCP) released a document named 'Doctors in Society' (32) in which they defined professionalism as:

> "Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust, the public has in doctors".

They further elaborated the definition by explaining it as:

> "Medicine is a vocation in which a doctor's knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability. In their day-to-day practice, doctors are committed to: integrity, compassion, altruism, continuous improvement, excellence and working in partnership with members of the wider healthcare team." (32)

The difference between the definitions of GMC and RCP is to address the immediate colleagues, which the RCP failed to mention although its overall definition is more elaborative than the GMC definition. The definition of the RCP is focused on public, probably due to the nature of the research project which is on the role of doctor in a broader society.

The Scottish Doctors presented a working model for the undergraduate medical curriculum which contained 'the doctor as professional' as one of the core competency (Figure 3) (25). A similar model was presented by a working group at the Ottawa conference in 2010 which identified Individual/Personal, Inter-personal, Institutional, and Societal domains of professionalism (Figure 4) (23). However, the objective of the conference meeting was not to set a definition for the professionalism but to identify ways to its assessment (23).

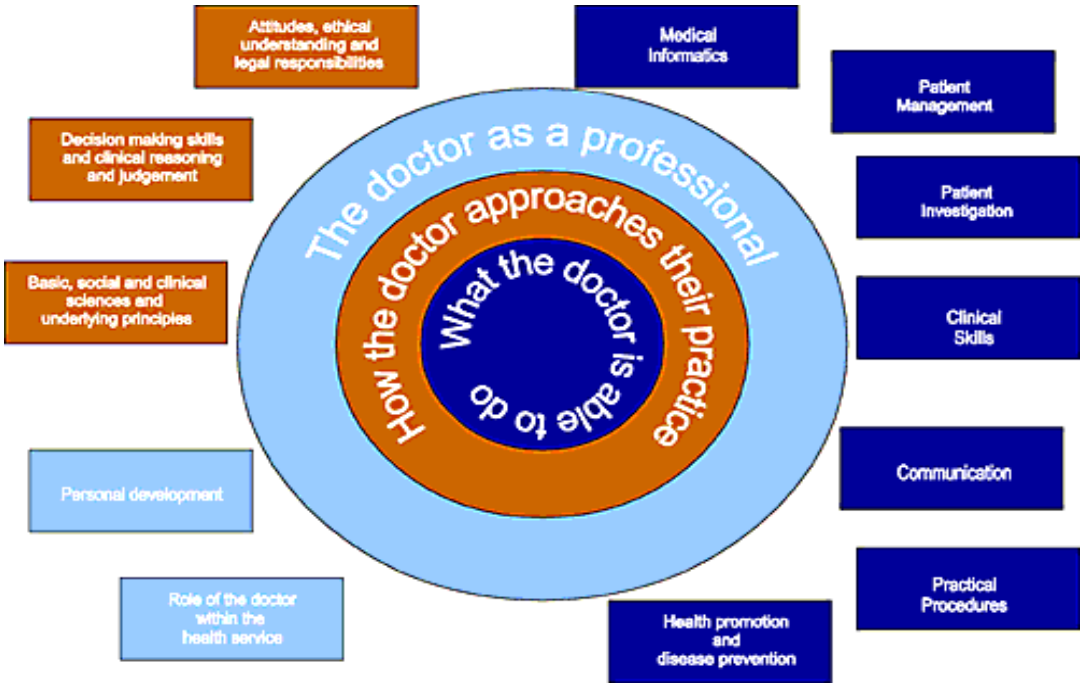


Figure 3: The Scottish Doctors Model for the undergraduate medical curriculum. Reproduced from Scottish Doctors (25).

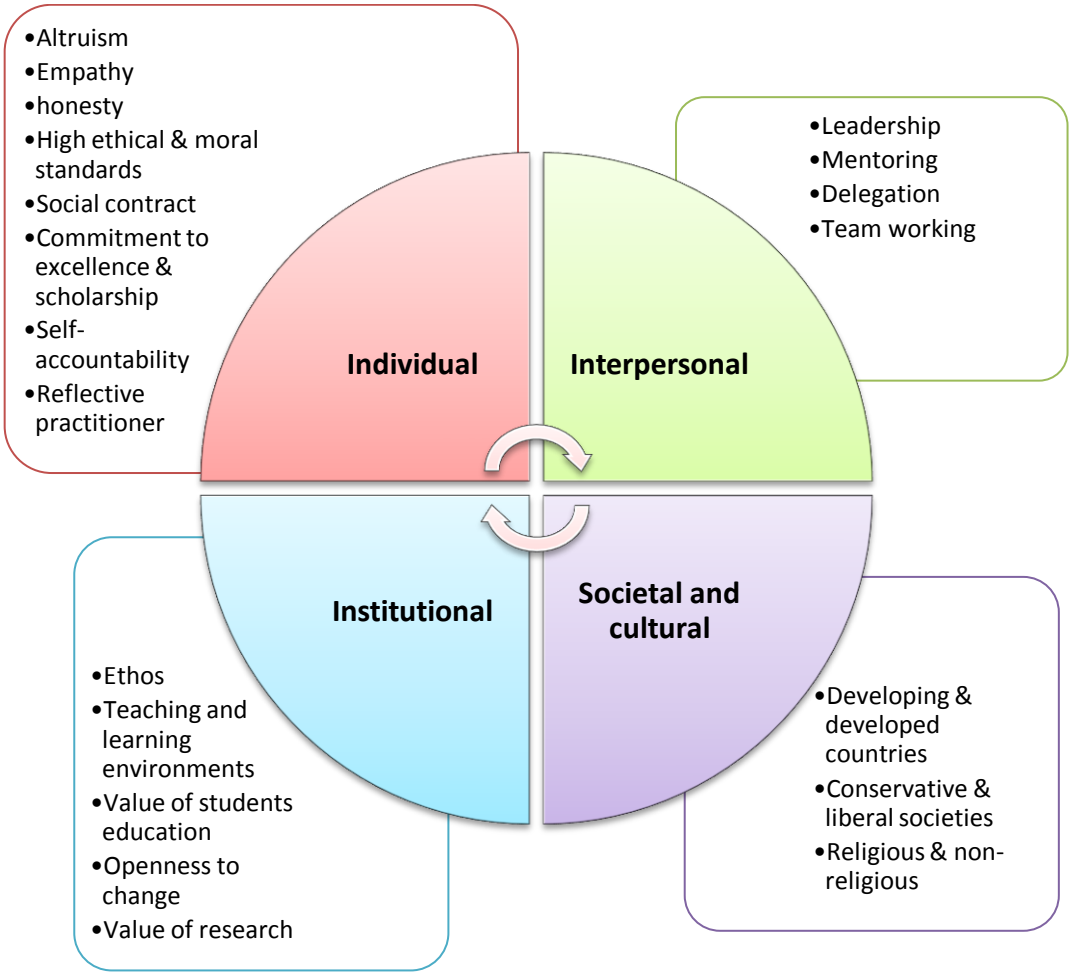


Figure 4: Domains of professionalism: multi-dimensional approach. Original diagram, compiled from information in Hodges *et al* (23).

Definitions by individual academicians

In the US medical schools, four attributes that are essential to professionalism are:

> "Subordination of one's self-interests, adherence to high ethical and moral standards, response to societal needs, and demonstration of evincible core humanistic values" (71).

These attributes were later presented as a normative definition of professionalism, which was a further elaboration of the previous research based on trust of patient and public on physicians (8). A set of behavioural components for physicians were presented as (8):

- Subordination of their own interests to the interests of others.
- Adherence to high ethical and moral standards.
- Response and to behave according to accepted social contract.
- Exhibit core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness.
- Exercise accountability for themselves and for their colleagues.
- Demonstration of continuing commitment to excellence.
- Exhibition of a commitment to scholarship and to advancing their field.
- Manage high levels of complexity and uncertainty.
- Demonstrate reflective practice.

These nine behavioural aspects from the USA were used in the study on students and professionals in Australia (92). The original nine components were modified into eight aspects (92). The sixth and seventh components: "*demonstration of continuing commitment to excellence*" and "*exhibition of commitment to scholarship to advance in their field*" were combined under an aspect of '*commitment to improve*'. This shows the variation in understanding professionalism in different cultural contexts.

Professional competence was defined as:

> "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." (72)

This definition considered professional competence as an ability or skill to act in a professional manner. Some of the researchers on professionalism criticize 'professional competency' as superficial professionalism and differ it from deep professionalism which is embedded in the attitudes (93). However, it is not possible to measure deep-professionalism or attitudes (66). Therefore some researchers prefer improving superficial-professionalism, embedded in the behaviours or

attributes of the medical students (38), for which definition of professional competency can be taken as a starting point (72). The difficulty with the topic is that most doctors think they know what professionalism is, and they can talk about it and can recognize instruments for assessing it but when it comes to making a definition, they find it difficult to define it (4). Swick (8) said that:

> "Professionalism is like pornography: easy to recognize but difficult to define".

A working definition of a profession was established by Cruess *et al* (94). It was based on the available literature and from the Oxford English dictionary (94).The proposed definition is as follows:

> "Profession: An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society" (31, 95, 96).

The set criteria establishes its base on medical knowledge and skills, and further includes service to others, abidance by the code of ethics, commitment to the competence, autonomy, integrity, morality, altruism, promotion of public good within their domain, self-regulation and accountability to the patients and society. The researchers have defined a profession, but not professionalism, which is personal and intrinsic to individuals working within the profession. However, the authors have agreed that different people define professionalism differently by stating:

> "There have been widely differing interpretations as how best to describe professionalism, with some researchers analysing the doctor-patient relationship or classifying a series of "traits" as being characteristic of professions." (31)

Influence of healthcare system on professionalism of doctors

A healthcare system is a complex adaptive system (CAS) (3). A complex adaptive system (CAS) is a dynamic, non-linear system which involves rich interactions between agents, with multiple feedback loops, and operated by a set of rules that changes over time, through encounters with the environment, and with each other (3). The agents in the healthcare setting are doctors, patients, public, and other stakeholders (3). The study of complexity involves how order emerges from the interaction of the agents, and has an historical element to it (3).

There are three distinctive features of a CAS (3, 97). The first is that the CAS is defined in terms of connections and patterns of relationships among agents (3, 97). These relationships are contextual, and depend on the nature of organization (3, 97). For example, in terms of healthcare setting, a doctor-patient relationship is different to a doctor-colleague relationship or a doctor to pharmaceutical manager relationship. Secondly, the CAS self-develop, and self-organize over time due to the everyday interactions of the agents (3, 97). The system does not require strong hierarchical structures, and the relationships enabled by architecture, grow and develop, over time (3, 97). A third important characteristic of CAS is that the system trajectory over time is fundamentally unknowable, as a result, there is an element of uncertainty (3).

The role of a team leader, as a health professional, is important in adapting to CAS to work efficiently and effectively (3). The focus of a team leader or manager in CAS shifts from knowing the world to understanding the world (3). The managers (doctor as a manager) attempt to design the future instead of forecasting it (3). They attempt to keep the structure fluid instead of finding the right structure, and use the system dynamically for its optimum performance (3). The responsibility for health is widely shared, and involves many stakeholders (3). Therefore, CAS requires a shift in leadership tasks, while working in a healthcare setting. Table 5 shows difference in leadership tasks while working in a CAS and comparing it to a bureaucratic system. The question for CAS managers and doctors is not which task can be eliminated, but rather, which is of greater relative importance. (3)

Table 5: Key leadership tasks for complex adaptive systems. Redrawn from Anderson and McDaniel (3).

Key leadership tasks	
Professional Complex Adaptive System	**Professional Bureaucracy**
• Relationship Building • Loose coupling • Complicating • Diversifying • Sense making • Learning • Improving • Thinking about the future	• Role defining • Tight structuring • Simplifying • Socializing • Decision making • Knowing • Controlling • Planning based on forecasting

Sociology and professionalism

The early articles from sociology consider medicine as a 'calling' (98). In addition to the knowledge and skills, they consider it as a set of values and behaviours that expresses an approach towards patients and colleagues, to enhance trust in a physician (98). The community expect values such as honesty and integrity from their physician and to have an attitude of humility and accountability towards patients, colleagues, and society (98). They demand professional behaviours which include a non-judgmental and respectful approach towards patients (98). In exchange for putting the interests of the patient and public first, physicians are accorded trust, respect, and confidentiality of patients (98). The traditional model of medical education emphasizes active learning by students working in the clinics and on the wards under the close supervision of full-time faculty (98). Previously, in an education community, the clinicians regarded teaching and patient care as a calling (98). The relation between the loss of community and the de-professionalization of medicine is best understood when considering the difference between a 'calling' and a 'career':

> "When one enters a profession as a calling, one assumes a definite function in a community and operates within the civic and civil rules of the community. When a profession becomes a career, the orientation is to impersonal standards of excellence, operating in the context of a national occupational system. To follow a profession has come to mean to 'move up and away'. Consequently, the goal is no longer participation in a local community but rather the attainment of success." (98)

The success is important but the intention here becomes worldly power, which has an element of indefiniteness and open endedness, that is, "*whatever 'success' one*

had obtained, one could always obtain more" (98). The extension of the healthcare system on one hand is good for standardization, regulation, and quality assurance. However, it has a drawback of putting the institutes in competition with each other for resources and funding, which changed the whole scenario for the health professionals (98). This environment of competition was further enhanced by the peer review journals whose standards for excellence further diminished medicine as a calling and as part of a community (98). Research became subject to the review of authorities outside the home institution (98). Although this provided a national standard of quality, it contributed to the faculty's pursuit of 'outside' funding (98). Additionally, patient referrals to the tertiary care hospitals for sophisticated diagnostic technology and medical therapeutics distanced the general practitioner from their local patient population (98). This system to some extent has been controlled in the UK, but in most countries, the local communities have lost their connection with the local doctors. Divorced from a local community, medicine gradually lost its professional 'calling' and became a 'career'. (98)

While the shift from 'calling' to 'career' is true for distancing the doctors from the community, conversely, it is important for improving the healthcare system. The de-professionalization of medicine may not necessarily halt the improvement of healthcare system. However, solutions need to be found to avoid the estrangement of doctors from the community. An example can be found in the National Health Services (NHS), UK where the General Practitioners work closely with the community while the specialists are located in the secondary or tertiary care hospitals. Some other ways through which de-professionalization of medical profession can be avoided are to develop an education community (99, 100) to reform the residency training, mentoring, a curriculum on professionalism, and the evaluation of professional conduct that may enhance medical professionalism (98). The medical schools in the UK and other countries have adopted such strategies and, in addition to the training in communication skills, professionalism and bioethics, the students have to go through their community projects with GP practices to gain a better understanding of the demands and expectations of the community. The focus of all these activities is on professionalism. This makes the physicians and medical students understand that, competition for prestige, wealth, and technical competency demoralises that which is valued most by society, that

is, the trust in the judgment of doctors to act in the best interests of patients (98). Thus, the dynamics of professionalism have changed with time and with evolution of medicine from 'calling' to 'career'.

However, despite the changes in dynamics of professionalism with time, trust remains as one of the key attributes, which is the building block of the concept of professionalism. 'Trust' as a concept is the key feature for doctors and it is also the main uniting factor among them (101). Trust itself is not a concrete concept and it changes and reforms itself in the light of an on-going struggle (101):

> "The trust can be taken in a twofold sense. It entails trust in a person's technical competence to do the job but it also entails trusting them and their professional colleagues to monitor and control their work and to ensure that the practices they perform are administered in a way that is agreed to be correct. This requires granting these occupational groups of wide range of autonomy and the freedom to manage and discipline themselves and their organisations" (101).

There is a decreasing level of trust placed in social service professionalism and its supporters, by powerful stakeholders such as the state and capital (101). In the light of this, certain groups within medical profession have sought to redefine professionalism and to prioritise commercial issues in an attempt to gain the trust of these stakeholders and to exploit opportunities (101). This exploitation may be illustrated by a probe of German doctors for bribery from the pharmaceutical companies (102). The hijacking of professionalism by commercialism is also criticized by other researchers with respect to the ways in which commercial forces are invisibly changing the definition of medical professionalism (93). This cleavage extends across the public sector-private sector divide and is also taking place within a previously relatively homogeneous profession (101). It is exemplified recently in Germany where self-employed entrepreneurial physicians were allowed to take cash from drug firms. They could not be charged with "*bribery of public officials*" (as defined in the German Penal Code) because they were neither civil servants nor representatives of a state institution (103). However, this division between public and private doctors may fragment their identity (101). It has also challenged the impression that medical doctors are homogeneous and conservative (101).

The movement to redefine professionalism is also seen by some as a break with the homogeneity and conservative thinking of doctors (101). It is regarded as an effort

to legitimise different types of cultural capital which may potentially split the service class (101). The doctors, as a service class, are to be distinguished from other classes by the following four features: the workers are trusted, they have a code of service, they have a relative security of employment, and they have prospects of material and status advancement (101). The term cultural capital is described as:

> "Non-financial social assets, for example educational or intellectual, which might promote social mobility beyond economic means" (104).

The sociologists see this debate as healthy for improving values, attitudes and behaviours of doctors but it is used against them by certain political groups to divide the service class and to break their homogeneity for political gains (101). This is achieved through voting and winning elections by changing the nature of the employment relationship of the doctors with their employers (101). The complex concept of using "*professionalism as enterprise*" was discussed in the context of the UK (101). Some people may appreciate this diversity 'in thinking' because society values change with time, level of education, culture, and the political situation where definitions of professionalism need a continuous evolution. There is a split in the recent and early version of professionalism which is based on the notion of social service and the new commercialised version of professionalism (101). The old definitions were centred on providing services based on needs, rather than the ability to pay while the new definitions prioritize the profits, meeting budgets, and managing patients and colleagues (101). Therefore, the definition of professionalism varies across different countries depending on the healthcare system (103).

Ethics and professionalism

Ethics is concerned with rules of conduct and principles relating to moral behaviour (105). The four principles of ethics namely autonomy, beneficence, non-maleficence, and justice provide culturally neutral principles and guideline to all doctors (106). Professionalism and ethics have many overlapping areas, yet are distinct from each other at both theoretical/academic and organizational levels. Both ethics and professionalism are dynamic and contextual in nature (10, 107). Moreover, ethical principles can inform professionalism, and communication skills

can be a manifestation of it (108, 109). In the law, ethics is considered as the minimum standard which is required from all the lawyers while professionalism is considered as the higher standard (110). In general, ethics is about 'doing the right thing', while professionalism is about following the 'rules and regulations' (111, 112). This relationship between ethics and professionalism is shown in the perspective of an outcome-based education model, where 'doing the right thing' is in the inner circle while 'professionalism' forms the outer circle, shown in Figure 5.

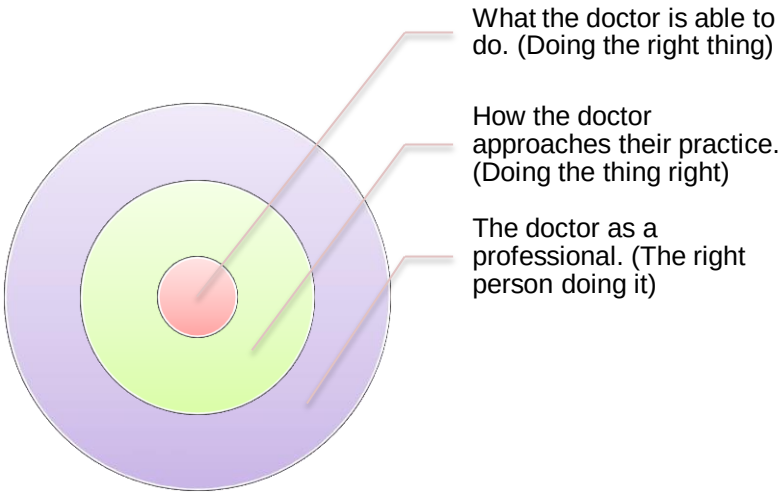


Figure 5: Relationship of ethics and professionalism. Explained with help of outcome-based education model. (113)

Another distinction between ethics and professionalism is that professionalism is about the issues which are explicitly and clearly mentioned and demarcated, such as 'under rules and regulations', which the doctors have to follow (112). Ethics is about the unsolved, grey areas or new dilemmas which may arise in complex workplace situations (112). Such ethical conflicts and dilemmas are common in the life of a healthcare professional. Professionalism provides a means to address these ethical conflicts and dilemmas through external regulation or self-regulation (14). The relationship between ethics and professionalism in this situation is shown in Figure 6.

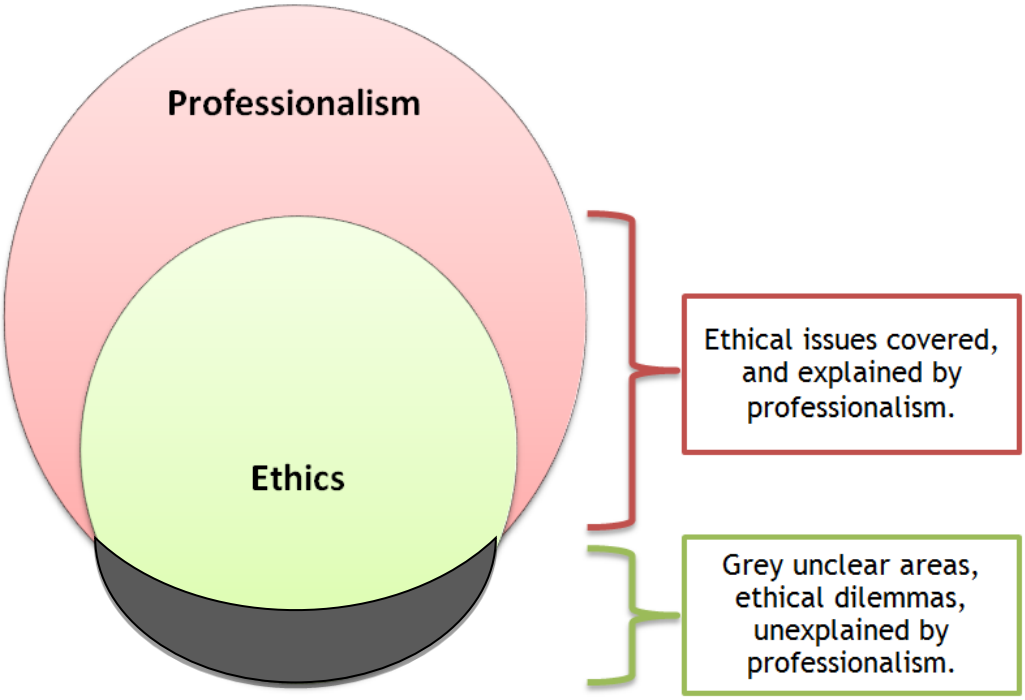


Figure 6: Relationship of ethics and professionalism.

The four pillars of ethics provide culturally neutral principles and guideline to all doctors, but the complex and contextual nature of healthcare environment require additional support from 'professionalism studies' to guide physicians in the right direction, and to take the right decisions, towards the care of patients (106).

Self-regulation and professionalism

The term self-regulation is broadly used across different disciplines. It may signify self-control in sociology and psychology, self-regulated learning in educational psychology, self-regulation theory as a system of conscious personal health management for the patients, self-regulatory organization, and self-policing as an internal self-regulation to abide by the laws, ethical, legal and safety practices (14-16, 114).

The advantage of self-regulation for individuals is that they can avoid the cost of setting up an external enforcement mechanism (114). In the context of professionalism, the term can be broadly used as self-policing, time-management, task management, and reflective practice for professional development (14). Self-regulation theory is a system of conscious health and professional management

system (115). It includes impulse control and management of short-term desires. People with low impulse control are prone to act on impulse triggers (114).

One way of developing self-regulation is through constructing reflective portfolios about professional practise (116). Other strategies may include developing an empathetic approach towards patients (117), by keeping themselves up-to-date by practising, and reading about the new concepts on ethics (115). These are ways in which doctors regulate themselves because, if they do not, then external bodies may start regulating them (31, 118). Since 2009, every year in the UK, more than 40 doctors lose their licence for their unprofessional practices. The cases are not because of knowledge or skills deficiencies, rather majority of the cases result from unprofessional behaviours and poor communication skills (119). The unprofessional behaviours and poor communication skills due to stressful conditions can be avoided by practicing self-regulation (115). This is the reason that the concept of self-regulation is important in the praxis and practice of professionalism (14).

Professionalism and identity formation

Identity formation of medical students and doctors has profound effects on their professionalism (6). Professional identity is the "*ways of being and relating in professional contexts*" (120). It is the perception of oneself as a professional, and is reflected in the professionalism of a student or a doctor. Both, professionalism and professional identity formation have many overlapping areas, and are closely related to each other, such as both are dynamic, experience dependent, and have multiple dimensions (6, 120). The teaching of professionalism, whether through formal curriculum or role modelling through informal curriculum may directly influence the identity formation of medical students and doctors (120). In this case, it is evident that professionalism is mainly learned through the informal and hidden curriculum (11). As a result, most of the identity formation is also through the informal activities (120). Formal activities can explicitly address the issue of identity formation but it is mainly the informal activities, which may have significant effect in the formation of identities of students (120).

The theme of professional identity formation is further divided into the following sub-themes.

- Dimensions of identity
- Multiple identities
- Role modelling
- Assessment

Dimensions of identity

Identity formation is mainly social and relational in nature (120). It has the same facets as that of professionalism, that is, an individual identity, relational identity (identity which is formed through inter-personal relationships), and institutional identity (identity formed by the ethos of the institute) (6). These identities are initially external to a person, and are later internalized (120). They are constructed and co-constructed all the time by interactions within the community of practice, and changing norms and culture of society with time, and hence it is not static but dynamic (6).

Multiple identities

The concept of multiple identities is important in this case as it defines the in-group and out-group at a particular time of the day, or a time frame (6). The in-group means "a group to which the student or doctor feels they belong, in a particular moment", while the out-group is the "group which is outside to their professional role or identity" (6, 120). The cultural variables such as race, gender, and ethnicity have an important influence in the formation of in-group and out-group identities (6, 120). The example of an in-group can be a 'white, male, medical student', and anyone outside this category may be an out-group (6, 120). The formation of in-group and out-group identity can also influence students' or doctors' approach towards patients, for example, a 'white, Jew, medical student' may feel more empathetic towards a 'white, Jew patient' (6). There are four different models according to which multiple identities are differentiated from each other: intersection, hierarchy, compartmentalization, and merging (6, 120). The importance of these different models is that those doctors or medical students

who are more inclusive, have larger in-group members and have a more complex understanding of social identity (120). These students or doctors are more open to change, and are less likely to be influenced by the power values (120). They are also more likely to value justice and are non-judgemental in their dealings with patients (6).

Role modelling

As discussed earlier, professional identity is mainly formed through the informal and hidden curriculum and role modelling has a strong influence on formation of identity (6, 120). There can be variation in role modelling in the formation of professional identity and professionalism; it can either be positive, negative or inverse role modelling. The positive role modelling is the one which is required from the teachers to exhibit so that the students can absorb it. This type of role modelling may show students how to behave and act professionally, such as a patient-centred or a person-centred approach in a consultation session. The negative role modelling may seem attractive and macho to the students on some occasions but in reality it is an unprofessional act, such as belittling a colleague on the basis of his knowledge or skills gap, while showing off with one's own knowledge and skills (6, 120). Such a behaviour or attitude may convey a message of arrogance or ego to the students, which some students may absorb because of the power factor (6, 120). The inverse role modelling is the one which is a negative role modelling on behalf of the teacher or doctor, but the students refuse to take it on moral grounds (6, 120). They become aware of these types of situations and avoid such behaviours. One such observation was a doctor trying to manipulate the identity of medical student as 'doctor in training', to take consent for the student to examine the patient (6). The student in this specific example told the truth to the patient that he is a Year 4 medical student, and not a 'doctor in training' (6).

Assessment

The identity formation can be assessed with the same instruments which are in place for assessment of professionalism (6, 120). The instruments at individual level can be self-assessment, peer feedback and assessment, 360 degree feedback, and reflective writings (6, 120). Some of the management models such as the

'Johari Window' may also be explored to address the issue of identity, to explore the unknown, known, blind and hidden self (121). The inter-personal or relational dimension can be assessed through feedback instruments such as, peer feedback and 360 degree feedback (6, 120). Institutional identity can be difficult to assess but management instruments, such as SWOT analyses, can help identify the factors which influence 'formation of identity' of individuals, and can be addressed accordingly (122).

Professionalism and power (dynamics)

"Power tends to corrupt, and absolute power corrupts absolutely. Great men are almost always bad men." (Lord Acton; 1834-1902; British historian)

The 'power of medicine' is a well-recognized factor which may lead to corruption or a lapse in professionalism, if not dealt wisely. One of the strategies to avoid corruption by power is, to devolve power (123). In a healthcare setting, hierarchy determines power, due to which, flat hierarchies are preferred in healthcare teams (123). There can be different levels of power depending on the stakeholders who are involved in the process, such as power dynamics between doctor and patient, where doctor is strong and patient is weak; power dynamics between a doctor and a student, where a doctor is strong and a student is weak; power dynamics between a doctor and a colleague where a senior doctor is strong and a junior doctor is weak; etc. The key questions here are about the implications of the power dynamics. Are these useful or harmful, do they have advantages or disadvantages, do we find the same psychology and same forces in their relationship, and how can a balance be established?

Power has been classified as sovereign power, weak democracy and strong democracy ('multitude,' or 'plural singularities') (123). The sovereign power was practiced in the traditional healthcare teams, where one individual was considered as the authority, and final decision maker (123). In the weak democracy, like-minded people made the decisions on behalf of the whole, while in a strong democratic team, individuals cherished their differences from each other and worked together for a mutual benefit (123). The strong democratic type of power was further devolved in the healthcare by introducing the concept of 'shared leadership', in which more than one team member shares the responsibility of

leading the team, according to the circumstances (124). The role of a leader in a complex adaptive system (CAS) theory also advocates for the devolution of power and flat hierarchies in a healthcare setting, for the optimal performance of the teams (3).

In healthcare, the exercise of self-regulation has been a robust practice to control the corruption of power (115). However, due to some high profile unprofessional incidents such as the Harold Shipman case and the Bristol Baby Heart Operation deaths from malpractice, an external regulation had to be established, which has shifted the power towards the regulator (123). This move of implementing a self-regulation process through external regulation has been appreciated by the public to regain their trust in the profession (123). It is also considered important for the quality assurance process (123).

Nevertheless, the professionalism movement in itself has been criticized as a move to maintain power by the healthcare professional bodies (123). In this case, the objection is that, the move has just shifted the power from an individual doctor to a regulator. However, this criticism is counter argued on the fact that, the regulator, GMC, has representation from many stakeholders. The power is decentralized among those stakeholders, thus reducing corruption by absolute power of one individual, and provides a balanced approach.

Curricula and professionalism

Professionalism is learned through the informal and hidden curriculum (11, 125), but it is frequently taught in the explicit curriculum (12, 17). The formal teaching of professionalism can be enhanced, if students observe and discuss the same desired outcomes through the informal and hidden curriculum (5). This can be done by promoting the culture of professionalism at the institutional level, which may require a faculty development programme with a focus on ‘professionalism of the faculty members’ (126). The focus on faculty is required because students observe and role model their teachers (74). Hence, teachers need to be explicitly trained in how to talk, act and behave in a professional manner in front of their students, and within the institute or organization, so that the students can take a positive message about their professionalism (74). The learning of professionalism through

different facets of curriculum can be understood from the Figure 7, which shows that professionalism is mainly learned through the hidden curriculum, followed by the informal, and then by the formal curriculum (127).

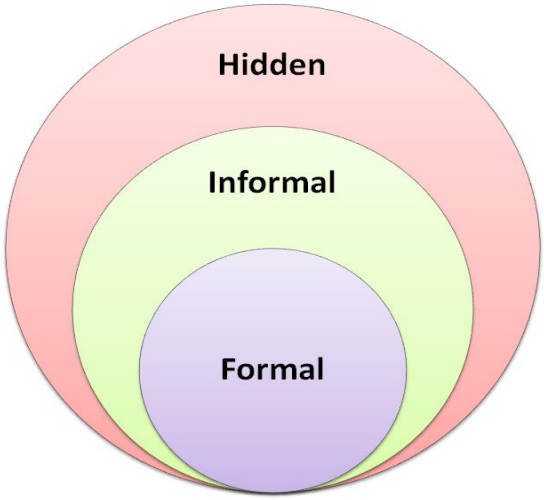


Figure 7: The learning of professionalism through formal, informal, and hidden curriculum. Redrawn from Rees (127).

There are three main types of curricula that have been considered for introducing professionalism formally at undergraduate or postgraduate levels. The first is the 'professionalism as competency framework' (128). The advantage of such a curriculum is that it is relatively easy to measure. The disadvantage is that such curriculum may miss the holistic picture, as every competency is measured narrowly by individual assessment instruments (128). The second option is the 'capability curriculum', which may consider professionalism as a capability (2). The advantage is that it provides a holistic overview of professionalism, and can test it as a performance in real life situations or in simulations (129). The disadvantage is that it is difficult to measure in real life situations (129). Even simulations such as near real life performance can be objected, as it is still simulation and not a real life scenario, so not truly measuring capability (129). The third format is an 'outcome model', that is, professionalism as an outcome (130). The advantage is that it is the most suitable model so far, as it uses both competency and capability as an internalization and externalization of the knowledge or skill or attribute (1). The model is focused on the outcome instead of the competency or capability. The disadvantage can be because of the gap in formal and informal curriculum, which may lead to multiple trajectories (131). These multiple trajectories can corrupt, the professional identity formation (6). The students may adapt different practices

in exam situation and in real practice (131). Figure 8 explains how a gap between formal and informal curriculum may lead to differences in trajectories. Different observations of professionalism can lead to divergent streams if the outcome for 'a professional doctor' is not addressed through both formal and informal curricula (131).

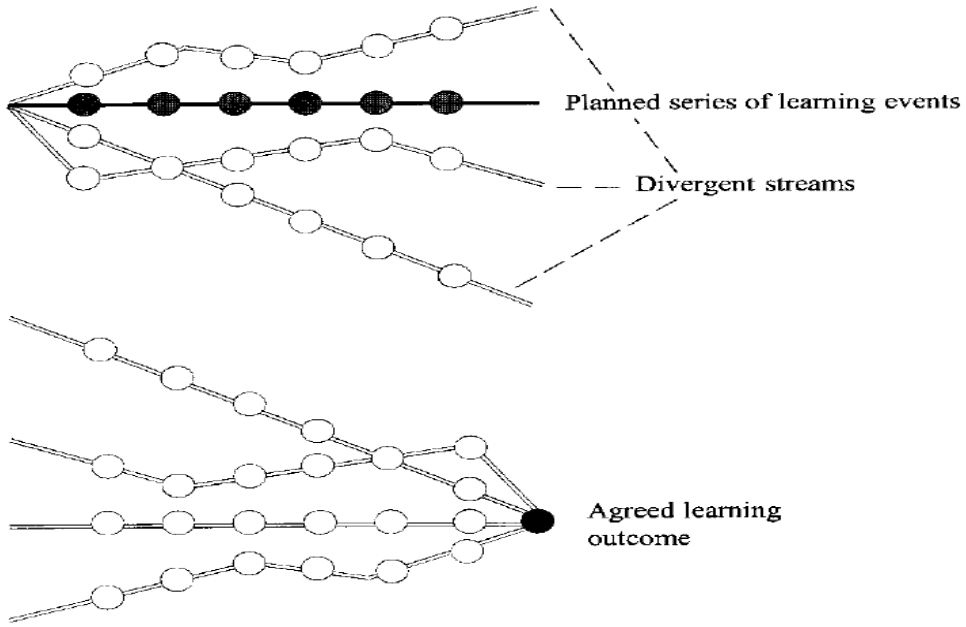


Figure 8: Learning trajectories for a non-outcome-based education model, and an outcome-based education model.
The first illustration shows how different observations of professionalism through formal, informal, and hidden curricula can lead to multiple learning trajectories. Reproduced from Ross (131).

The focus needs to be on reducing gaps in the formal and informal curriculum by standardizing the learning outcomes (11, 132) and this could be done by both faculty development and training of the students (74). Another means is to explicitly inform the students of the multiple constraints, which a doctor may face in a real life situation, thus bringing in the informal curriculum (5). In this way, the students may be aware of the different formats and will know how to adjust their professionalism according to different situations (5).

Measurement of professionalism

In the literature, there is a debate on what to measure and how to measure professionalism (66). The early concept of measuring attitudes and values shifted towards the measurement of behaviours (38). The background was that the attitude or value is considered intrinsic to the individual and they are groomed to develop those attitudes (66). Giving feedback to students based on their professional attitude and value can be devastating for them as they may think it as an internal fault and a weakness in their personality (66). Another argument was that it is not possible to measure attitudes because the professionals can disguise attitudes by their behaviour (66). Accordingly, the concept was shifted towards measuring behaviours which is what was required from professional doctors (38). It was also argued in early 2000 that observations are the best method to measure professional behaviours but later, a suggestion came that objective assessment of professionalism is more important (133). It was further realised that professionalism is a multidimensional topic and multiple assessment instruments are required to measure and assess it (134). The concept further developed from measurement of behaviours to assessment of attributes (38). The word 'attribute' was operationalized as, 'a behaviour seen in a specific context' (38). This indicates that the definition of professionalism can address specific behaviours but the context changes with situations, which may make it difficult for a definition to encompass all the contexts and situations. Moreover, the behaviours can be addressed in the definition but it cannot address all the professional scenarios and contexts in the given situations. Therefore, the attributes (behaviours according to specific situations) can be left for the assessment instruments to assess them in specific given contexts, while one can address 'behaviours' in the definition (38). One of the reasons for the difficulties in the assessment of professionalism is because the topic is subjective (135). Another reason is that the norms of societies change with time due to which it is not possible to use a similar definition over the years and needs an updating of the definition, consequently affecting the choice and use of assessment instruments (17).

Summary of the literature

In this review of the different aspects of professionalism, one core finding is that context matters when defining professionalism (10). There are differences between traditional and new views of professionalism (4). The traditional descriptions focused on attitudes and values but the new professionalism focuses on the behaviours and attributes (66). There are also differences between the United States (US) and the United Kingdom (UK) explanations of professionalism where the US definitions were mostly based around 'altruism' while the UK definitions were addressing a 'patient-centred' approach (4). In the UK, professionalism is associated with doctors' attitudes and behaviours while excluding scientific knowledge and clinical performance from the equation (4). The US physicians place more definitional weight on scientific knowledge and technical competence, leaving attitudes and behaviours to a category more akin to deportment or etiquette than professionalism (4). There were dissimilarities between medically and sociologically grounded depictions, where the medical based definitions were focusing on self-regulations while the sociological definitions were concerned with the doctors' role in society and how they are perceived by the people around them (4). One of the issues with the definitions was to identify a core dimension (is it knowledge and skills, or attitudes and values?) depending upon the normative and structural differences between different healthcare systems (4).

Other areas such as ethics, self-regulation and identity were also reviewed, with respect to professionalism (6, 115, 136). Professionalism is providing a practical guideline to ethics, but at times, there might be some dilemmas that are not yet outlined by the professional bodies (111, 112). Self-regulation, like professionalism has many dimensions, and is imposed by external regulators for quality assurance process (14). Development of professional identity is important for professionalism of doctors, and the early exposure of students to identity issues may help in developing their professionalism (6).

Although professionalism is mainly learned through the informal and the hidden curriculum, some literature suggests importance of its explicit teaching through the formal curriculum (5, 11, 126). The three main curricula that are used for teaching,

learning, and assessment of professionalism are, competency, capability and outcomes based models (128-130). The outcome-based approach uses both competency and capability in the continuum and provides a better curricular strategy (130). Multiple assessment instruments are required to assess different dimensions of professionalism (134). While measures have been taken to assess professionalism objectively, it is still better assessed with qualitative assessment instruments such as, reflective portfolios (135).

Chapter 3

Theoretical Framework

Chapter 3: Theoretical framework

Key points

- Cultural Historical Activity Theory (CHAT) is defined as: "*a specific form of societal existence of humans consisting of purposeful changing of natural and social reality*" (1).
- The three main areas of the theory involve the influence of history, culture, and activity.
- The theory provides a framework which helps in understanding the inter-relationships between, goals, motives, actions, roles, operations, artefacts, and aspects of social and organizational contexts, in which these activities are framed.
- Cultural Historical Activity Theory stresses its use in the studies which are contextual, and consider both 'theory' and 'active experimentation' as part of the study (1).
- 'Professionalism', is taken as the collective work activity in this study.
- Cultural Historical Activity Theory can be used in congruence with many research paradigms and methodologies, such as, constructivism or interpretivism, case studies, grounded theory, and critical theory.

Cultural Historical Activity Theory (CHAT)

Cultural Historical Activity Theory (CHAT), often commonly known as Activity Theory (AT), is used to explain expansive learning, and is a useful framework for examining learning to become a professional (1). It links the individual with the social structure (1). Some researchers argue that the CHAT is different from AT. I could not find any reference for such difference but after discussions with a social scientist, I found that this division might be on the basis of the generation of the theory (1). There have been three generations of CHAT since its introduction in the 1920s from Soviet Russia (1). The 1st generation had a strong basis for culture and history, whereas in the 2nd and 3rd generation, the focus was more on activity which has led to some wanting to differentiate CHAT from AT. The focus may have changed because of the use of AT in computer research in which CHAT is used but

the theory, itself, is still the same and has the same potential to comment on culture and history, even in its 2nd and 3rd generation (137, 138). The model in Figure 9 shows the three triangles in the CHAT, and their relationship to each other. The 1st generation of CHAT had only one triangle, which is at the top (1). The lower two triangles were later added to the activity system, and the theory was thus, called as 2nd generation Activity Theory. The 3rd generation involves the influences and comparison between two parallel activity systems (139).

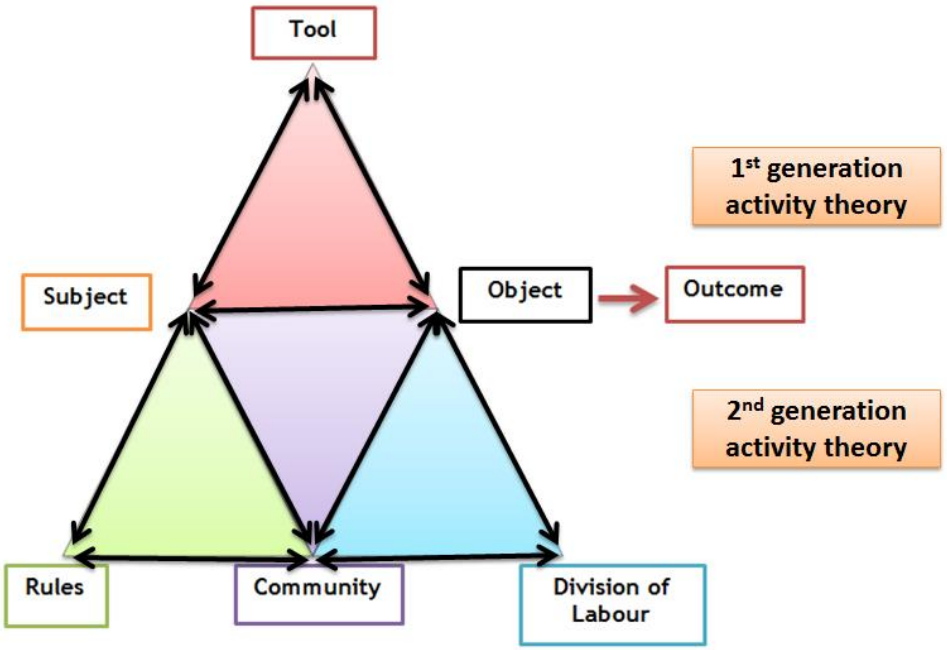


Figure 9: A model of Cultural Historical Activity Theory. Redrawn, with modification, from Engeström (1).

Initially, some other theories were considered that closely resembled CHAT such as, community of practice, culture value theory, and culture dimension theory by Hofstede but after a detailed reading, it was realised that they had differences in their 'unit of analyses. For instance, Community of Practice had a broader unit of analysis and finds it difficult to comment on individuals, unlike CHAT, which can comment on both individuals and broader context. The resemblance is because 'Community of Practice' originated from the studies of CHAT (1). The Cultural Dimension Theory by Hofstede provides a framework to compare different cultures (20). The four dimensions that provide comparison of Western culture to Eastern culture are based on power distance, individualism versus collectivism, masculinity versus femininity, and uncertainty avoidance (20). However, the findings of the theory are based on a business company, IBM, that works differently compared to

healthcare organizations (20). Healthcare organizations work in a complex adaptive system where the aim is provision of service as compared to business system where the aim is a monetary gain (3). Moreover, Culture Dimension Theory provides a closed framework as compared to CHAT which provides an open strategy that can be adjusted according to the given situation. Furthermore, Culture Dimension Theory was not used, to avoid repetition, because it has been previously used to understand professionalism with respect to cultural differences (19).

For this study, I have used CHAT to understand and explain professionalism in different cultural and organizational settings. The theory may be explained by answering two questions which will clarify why it has been used, and how it may benefit this study. The questions are:

1. What is Cultural Historical Activity Theory?
2. Why it is used in this study?

What is Cultural Historical Activity Theory

Introduction

Cultural Historical Activity Theory (CHAT) is a 'sociocultural theory', defined as: "a specific form of societal existence of humans consisting of purposeful changing of natural and social reality" (1). An activity carried out by a 'subject' includes 'goals', 'means or tools', the 'rules', 'community', 'division of labour' in shaping the 'objective', and the 'outcomes or results' (1). In fulfilling the activity, the subject also changes and develops him/herself (1). This theory may be employed to different aspects of individual development and social transformation (1). This transformation steps beyond the frames of given situation, and includes the wider societal and historical context (1). This study has explored the activity of professionalism which is influenced by multiple factors such as, development of culture, history, role of economics and religion on society, formal and informal curricula, and other observations in healthcare setting.

The principle of CHAT is that a 'collective work activity' is done, driven by a 'goal', which is shared by the 'community'. The subjects use tools, instruments or artefacts, to understand and solve a problem, that is, an 'object or objective', in

terms of Activity Theory. During this process, they follow some 'rules' which govern them and provide them guidelines. The community share the collective activity having different roles, that is, division of labour to understand a problem. This shared collective activity helps in the achievement of the 'outcomes', which in this case are the similarities and differences in understanding professionalism, in different cultural contexts. The theory provides a framework which helps in understanding the inter-relationships between, goals, motives, actions, roles, operations, artefacts, and aspects of social and organizational contexts, in which these activities are framed (140).

Cultural Historical Activity Theory provides a 'theoretical framework' from which we can understand the inter-relationship between activities (for example, the formal and informal teaching activities for professionalism), actions (for example the practices, which may include role modelling, communication skills of doctors in OPD or at bedside, etc.), operations and artefacts (instruments for teaching, learning, and assessment of professionalism) , subjects' motives and goals (motives can be patient satisfaction or good impression on either patient or doctor, and goals can be continuous zeal or excellence to be a professional doctor or to become a highly professional doctor), and features of the social, organisational and societal contexts within which these activities are framed (140).

'Professionalism', was taken as the collective work activity in this study. It included professionalism at personal, inter-personal, organizational, and societal levels (23). The purpose of this study was to identify similarities and differences to understand professionalism in the context of Scotland and Pakistan. The 'community' of medical doctors were considered from both the countries. The 'subjects' in this study were the medical students and faculty members from six medical schools from both countries. The problem, or the 'object', was 'understanding professionalism in the cultural context', mediated by the 'tools' such as focus group discussions and semi-structured interviews. The cultural factors, in general, were considered at institutional and societal level because both reflect the cultural constraints of the society and the healthcare system (1).

The 'rules' in this collective activity of professionalism were multiple. Some of them were pertaining to carry out the activity, while others were forming the activity. Those which were carrying out the activity were the ethics procedures, consents from the respondents, and protocols for data collection and analysis. The rules which were forming the activity were the institutional and departmental rules, the external regulators such as PMDC curriculum, and the GMC and Scottish Deans' Medical Curriculum Group for Scotland documents such as 'Tomorrows doctors', 'Good Medical Practice', and 'Scottish Doctors', etc. The 'division of labour' again was at multiple levels such as hierarchy between doctor, patient, his attendants and relatives, students, colleagues, trainees, and other healthcare professionals for example nurse, dentist, physiotherapist, pharmacist, etc. This segment of CHAT can explain the dynamics of professionalism such as, power dynamics, identity formation, and role modelling, etc. Figure 10 shows model of activity system with relevant examples from this study.

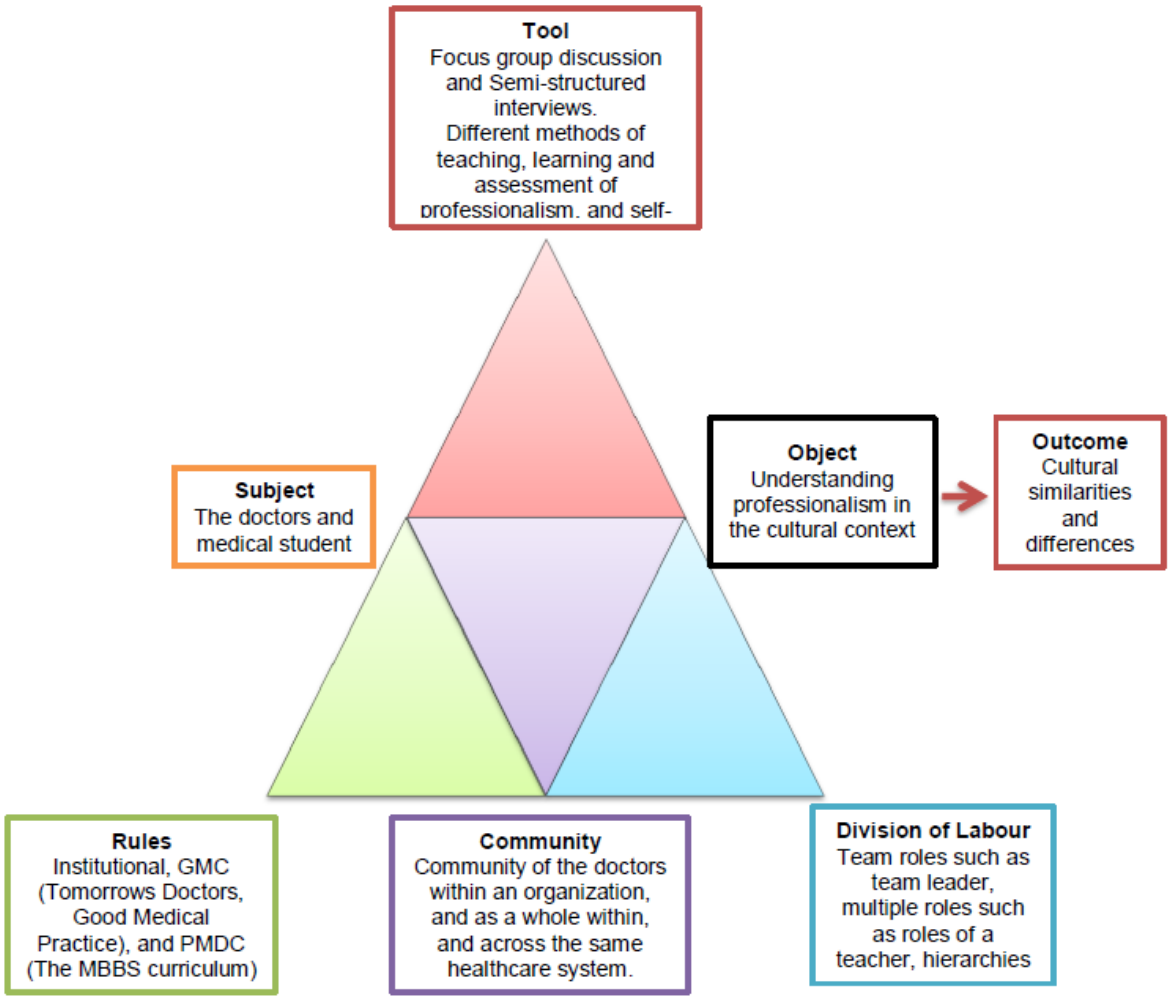


Figure 10: A model of activity system with relevant examples from this study.

The three level scheme of CHAT (1), that is,

- Activity
- Action
- Operation

Corresponds to:

- Motive
- Goal
- Instrumental conditions

The scheme is further clarified, by putting it in the context of this study, in Table 6.

Table 6: Terms used in the Cultural Historical Activity Theory in the context of this study, explained with examples.

CHAT Terms	Examples, in context of the study
Activity	For thesis: The whole process, including all external and internal factors for example, establishing contacts for data collection, getting ethics approval, making protocols for data collection and analysis, collecting data, etc. For the topic of the study: The whole process of professionalism, including multiple themes such as probity, teamwork, dealing with colleagues, self-regulation, conflict resolution, etc.
Action	Per day schedule of a doctor
Operation	Consultation for 15 minutes, communication skills session
Motive	Image of a doctor
Goal	To spend day, professionally. Patient satisfaction, excellence in professionalism
Instrumental conditions	A ward, clinic, OPD or OT conditions. Teaching and assessment instruments

The CHAT stresses its use in studies, where both 'theory' and 'active experimentation' are parts of the study (1). This feature of CHAT is in congruence with this study. The reason for active experimentation is to observe the activity, which is not possible in case of a review study only. This study though, does not include active experimentation in its true sense as there is no intervention, but it is an analysis of the subjects in their social context, which gives an insight about the healthcare system, and to understand the cultural differences in professionalism.

Another additional factor of CHAT is its focus on 'context' (1). Professionalism is also known for its context specific nature, which shows congruence between the topic and the theory. Thus, an idealist activity theorist may not consider this study

as a true ‘activity to bring change’ but it does provide a framework for understanding professionalism in different cultural ‘contexts’.

The two important elements in CHAT are the objects (objectives) and motives. The reality is constructed by using the objects with defined motives (1). In case of professionalism, the ‘object’ can be taken as the learning of professionalism, which is again divided into external part (explicit), and the internal part (the conceptual value or implicit). The motive here is to become a professional doctor. The doctor achieves his/her goals of becoming a professional doctor after learning about professionalism either through formal training or informal learning. This process is called transformation of activity for example, to transform from unprofessional to professional, from superficial professionalism to deep professionalism. In the context of this study, the general object is to ‘understand professionalism in the cultural context’ and the general motive is to provide new perspectives on professionalism that address cultural sensitivities. However, there are many small activities going on within the collective activity, that have specific ‘objects’ and ‘motives’. An example of a specific object can be ‘informal self-regulation’, for which the motive may be ‘image of the doctor’.

Key features of Cultural Historical Activity Theory, and its congruence with professionalism

1. Cultural Historical Activity Theory is ‘dynamic’ (1). This feature of CHAT is congruent with professionalism. The literature on professionalism also proves it to be dynamic (23). The use of CHAT may enhance understanding professionalism in the cultural context, as they both share some similar characteristics.
2. Cultural Historical Activity Theory recognizes its internal contradictions and recognizes them as an essential feature of the theory because these weaknesses provide debates on its further improvement (1). Professionalism, as a concept, also recognizes its conflicts and limitations, and considers it as an essential part for professional development (10).
3. The theory helps in understanding levels beyond actions (1). In this study, the emphasis is on understanding cultural similarities and differences, and

how it can help in providing new perspectives on professionalism, which can address the cultural issues.

4. 'History' makes part of the unit of analysis of the CHAT but the unit of analysis has to be manageable (1). An individual or individually constructed situation limits the role of history in the unit of analysis (1). In this study, professionalism is taken as collective activity system. This helps in managing history as part of unit of analysis, and also steps beyond the limits of the individual biography (1).

Previous use of Cultural Historical Activity Theory in medical education

Cultural Historical Activity Theory has been used previously in simulation, such as for peer physical examination (PPE) (139). The study used CHAT to theoretically understand PPE as a learning method. The students from six medical schools shared their views on the complexity in relationships in peer physical examination and genuine patient examination (139). They explained how these two types of relationships differed in nature and levels of interaction. The complexity around relationships, rules, and community were explained using the CHAT model. The study provided recommendations for educational practice and further research based on principles of CHAT (139). I am using CHAT in this study to understand professionalism across different cultures. The second and third generation of CHAT helps in comparing medical schools within the country and across the countries, that is, comparing different activity systems with each other. This also helps in generalizing the findings of the study to medical schools with similar internal and external factors.

Use of Cultural Historical Activity Theory with research philosophies and methodologies

Cultural Historical Activity Theory (CHAT) can be used in congruence with philosophical perspectives such as the constructivism or interpretivism or transformative constructivism (1). The constructivist approach explains how society is reformed over the time (141). The societal values and norms are developed over time which shows its link to the history (1). Moreover, CHAT can also be used with different qualitative methodologies, such as ethnography, grounded theory, critical theory, and case study (1). One of the key features of CHAT is that it reveals the aspects of the organisational and societal contexts within which these activities are framed (1). This study used Cultural Historical Activity Theory (CHAT) to understand the local phenomena in greater detail. It has helped at all levels of exploration, description, and analysis of the culture of professionalism in the local context, and provided a framework to compare different cases with each other.

I have used theory in this study for three reasons. Firstly, the recommendations from the previous research laid the foundations for this study (19, 33), in which a qualitative study was suggested across different cultures to understand professionalism in local contexts. Secondly, case study approach was used in this study which is based on the 'unit of analysis' and CHAT offers a framework for the unit of analysis. This unit of analysis enhanced my understanding of how people work within healthcare system, and considering their role in society. Thirdly, the case study as a methodology in itself emphasizes on the use of theory to search for possible answers to 'How', and 'Why' questions (142, 143). The focus of this study was also on the 'How', and 'Why' questions. There was congruence between the research questions of the topic (professionalism), and the situations where, the use of theory is recommended in case study research (142, 143). Combining these three factors, I felt that a theory was required for the quality of this study (144). Moreover, the use of CHAT as a theory was also looking at the dimensions of 'culture' and 'context', which were the focus of this study (1). Thus, the theory has not only helped in the initial organization and analysis of the data, but has also provided framework for the unit of analysis (142, 145).

Limitations of Cultural Historical Activity Theory

Some limitations of CHAT, relevant to this study, are given below.

1. Transformation: One of the issues raised by CHAT researchers is that, in Activity Theory, the transformation of the object is internal transformation (1). This is one of the limitations of the use of CHAT in this study as I am not able to prove that the data collection procedures actually made the study participants think about professionalism and to act according to the standard norms.
2. Collective and individual activity: Some of the researchers of CHAT argue on the internalization of the activity whether the internalization is at individual level or collective level (1). The idealistic situation can be if all the medical students and faculty members internalize professionalism and start regulating themselves, which may not be possible and cannot be measured within this study. The study cannot comment at an individual level whether any individual student or faculty member actually internalized their views and thinking about professionalism due to this study.
3. Structure and components of activity: One of the objections of CHAT is that the model does not provide any means of solving the problem (1). Moreover, the components in its model are general to any activity, and do not provide insight into any specific features.
4. Different kinds of activity: The fourth problem is the classification of different kinds of activity (1). Activity in its true sense is connected to the transformation of reality, which was not the main aim of this study (1). Moreover, different fields use some predominant version such as, a sociologist mainly uses CHAT to understand the societal aspects, whereas an anthropologist focuses on the cultural aspects, and the historians' main focus is on the historicity in Activity Theory (1). An effort has been made to address all the three predominant types of CHAT, to understand the culture in light of the historical background and societal forces affecting the professionalism of doctors and medical students.
5. Communication: Some of the researchers of CHAT do not want to mix activity with communication and are in favour of keeping them distinct (1). However, it is evident from the new literature on CHAT, that communication

cannot be separated from the activity (146). It is one of the main parts of societal existence (1). In its deepest sense, this intends the linguistic analysis of the data, leading to discourse analysis (1). Discourse analysis has not been used in this study but highlights how 'communication skills' forms part of an activity.

Why Cultural Historical Activity Theory is used in this study

Cultural Historical Activity Theory has been used in this study for the following reasons.

- The theory provides a framework for the 'unit of analysis' of a case study. This framework will be consistent for all the cases to make comparisons between them. The framework consider different dimensions of professionalism such as, the role of the community, teamwork (division of labour), guidelines (rules), different methods of teaching, learning and assessment available for professionalism (tools), and how they are inter-linked to the study participants (subjects) and the objective (object) of this study.
- The unit of analysis of CHAT also provides framework for data analysis, known as framework analysis, which can be used along with other data analysis techniques, such as thematic analysis (147, 148). The framework analysis is based on an already provided conceptual model of CHAT (149). In this case the already provided framework included the six key themes of activity model. These include the subjects, the objects, the rules, tools, community, and division of labour.
- The theory explains learning in context and argues that learning is not just a cognitive process within the brain but it is affected by the external environment (1). The external environment in this case is the different cultural contexts.
- The theory helps in commenting on the broader social patterns, such as the cultural factors within an organization and in the healthcare system (140). This is also the crux of this study, to understand professionalism at the level of organizations and healthcare systems.

Chapter 4

Methodology

Chapter 4: Methodology

Key points

- The philosophical position is constructivism or interpretivism.
- The methodology is qualitative case study.
- The sample included three medical schools from Scotland and three from Pakistan.
- There were two groups, clinical years' medical students and clinical faculty members, from each medical school.
- Data was collected through Focus group discussions (FGDs) and semi-structured interviews (SSIs).
- The data was analysed thematically.

Introduction

This chapter describes the methodology, and justifies why constructivism/ interpretivism have been used in preference to positivism, post-positivism, critical theory, and postmodernism. Interpretive studies are one of the most common forms of qualitative research found in education (141). Data is collected through interviews, observations, and document analysis (141). The analysis of the data involves identifying recurring patterns or themes that characterize the data (141). The overall interpretation is the researchers' perceptions on the participants' understanding of the phenomenon of interest (150). Cultural Historical Activity Theory is used as a theoretical framework for investigating professionalism. The steps taken and instruments used in the methods included purposive samplings for semi-structured interviews and focus group discussions in a cluster of case studies. The use of qualitative case study research terminologies have been further explained in this section.

The methodology in this study is arranged to answer the following research questions.

- How do cultural differences affect the professionalism of doctors?
- How do medical students from different cultures perceive professionalism?

- What are the cultural similarities and differences in understanding professionalism, within a country?
- What are the cultural similarities and differences in understanding professionalism across cultures?

Figure 11 provides an overview of, how the topic of culture of professionalism was observed from different angles.

Figure 11: Discussion of the research topic from different angles.

The methodology chapter is divided into the following areas.

- Philosophical perspective/paradigm
- Methodology selected for this study
- Development of questions for interviews and focus groups
- Selection of the sample
- Sampling techniques
- Data collection methods
- Data analysis techniques

- Quality of the study
- Interpretation of qualitative data: the issue of reflexivity

Philosophical perspective or paradigm

I have used an interpretive paradigm which assumes that reality is socially constructed (151). There is no single observable reality rather there are multiple realities or interpretations of a single event (151). The knowledge is constructed instead of being 'found' (151). Constructivism is a term often used interchangeably with interpretivism and most qualitative research is located in the interpretive paradigm (151).

The other paradigms which are commonly used in research are positivist, post-positivism, critical research and post-structural or postmodernism. A positivist orientation assumes that reality exists out there and is observable, stable and measurable (151). The knowledge gained through the study of this reality is labelled 'scientific' and includes the establishment of laws (151). Experimental research and surveys frequently assume a positivist stance. The rigidity of this perspective has given way to post-positivism which recognizes knowledge as a 'relative rather than absolute' but holds that, it is possible to distinguish between more and less possible claims (105, 151).

A critical research paradigm goes beyond uncovering the interpretation of peoples' understandings of their world (151). Critical research has its roots in several traditions and currently encompasses a variety of approaches (151). Those who engage in critical research tend to frame their research questions in terms of power, 'who has it', 'how it is negotiated', 'what structures in society reinforce the current distribution of power', and so on (151). My aim was only to interpret the views of the respondents without going into the discussion of the power and politics and so I did not use the critical paradigm in this study. However, power is one of the important themes in the literature on professionalism, and hence, critical theory can be used as a methodology for professionalism studies whose focus is on 'power' and to bring about change.

A fourth orientation is post-structural or postmodern paradigm. While research from a postmodern perspective is quite different from the previous three forms discussed, nevertheless it influences our thinking about interpretive qualitative research and also critical research (151). A postmodern world is one where the rationality, scientific method, and certainties of the modern world no longer hold (151). According to postmodernists, explanations for the way things are in the world are nothing but myths or grand narratives (151). There is no single 'truth'; rather there are multiple 'truths' (151). Postmodernists rejoice at the diversity among people, ideas, and institutions (151). By accepting the diversity and plurality of the world, no one element is privileged or more powerful than another (151). Congruent with this perspective, postmodern research is highly experimental and creative, and no two postmodern studies look alike (151). This perspective is sometimes combined with feminist, critical theory, and queer approaches (151).

I have used a constructivist approach in this study because the reality is constructed by the interaction of the respondents with their environment (151). This may lead to multiple realities however the process of triangulation is used to validate the data (152). Another reason for selecting a constructivist approach was on the philosophical ground that some postmodern researchers perceive that people in society are more interested in their self-interest than those of the state or regulating bodies (153). The self-interest may lead to moral relativism, that is, morality is relative to a person (153). In other words, there are no set rules that universally apply to everyone which may contribute to deviant behaviour (153). In research on professionalism, one has to follow the law and regulations set by the State and the professional bodies to work within the defined professional limits and legal boundaries, thus, a post-modernist approach was not suitable in this case.

Methodology

The main methodology used in this study is interpretive qualitative research, sometimes also known as a generic, basic or interpretive study (150). A central characteristic of qualitative research is that individuals construct reality in interaction with their social worlds (150). The interest is in understanding the meaning of a phenomenon for those who are involved (150). Meaning, however, is

not discovered but constructed (154). Meanings are constructed by human beings as they engage with the world they are interpreting (154). The overall purpose is to understand how people make sense of their lives and their experiences (150).

Although this understanding characterizes all qualitative research, other types of qualitative studies have an additional dimension (150). For example, a phenomenological study seeks understanding about the essence and the underlying structure of the phenomenon but the researcher cannot be part of this understanding, and has to detach himself from the reality construction (150). Ethnography strives to understand the interaction of individuals not just with others, but also with the culture of society in which they live (150). A grounded theory study seeks not just to understand, but also to build a substantive theory about the phenomenon of interest (150). Narrative analysis uses the stories people tell, analysing them in various ways, to understand the meaning of the experiences as revealed in the theory (150). Critical qualitative research focuses on societal critique in order to raise consciousness and empower people to bring about change (150). If the unit of analysis is a bounded system, a case, one would label such a study a qualitative case study (150).

I considered and read different methodologies for their suitability to this study. The first methodology which I considered was a grounded theory. I found that it is suitable only if the aim of this study was to build a theory, which was not the case. This study itself used an already available theory, that is, Cultural Historical Activity Theory. However, there is an element of grounded theory at the data analysis stage where some new themes emerged, but those individual themes cannot be considered as a grounded theory.

Another methodology which could match to this study was ethnography. This study was using CHAT, as a theoretical point of reference, which has a cultural element in it and ethnography is also the ‘study of culture’ (155), in which the researcher immerses himself within the culture under study. In this study, there was an ethnographic element to the extent that I had spent sometime in the respective medical schools but it cannot be considered as immersion into that culture. Moreover, it is not necessary to use an ethnographic methodology with CHAT, as there are examples where CHAT is used with case study technique (156, 157). The

reason is that CHAT provides a framework for the unit of analysis of a case study (140). Therefore, a case study approach has been used within basic qualitative research to provide an in-depth analysis of the data from the individual medical schools (150).

Qualitative case study

A case study is an in-depth description and analysis of a bounded system (158). Yin (159) defines case study in terms of the research process. He says that:

> "A case study is an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident".

Stake (160), however, focuses on trying to pinpoint the unit of study, whereas Wolcott (161) sees it as: " *an end product of field oriented research*" rather than a strategy or a method. Case studies can be quantitative, qualitative or mixed according to the research question and purpose of the study. The choice of data collection instrument and its analysis again depends on the research question and purpose of the study. Qualitative case studies search for meaning and understanding just as other forms of qualitative research (158). The researcher is the primary instrument for data collection and analysis, using an inductive investigative strategy to attain a richly descriptive end product (158). This section is further divided into the following headings.

- The concept of 'a bounded system' in the case study
- Types of case studies
- Strengths of a case study research
- Limitations of a case study research

The concept of 'a bounded system' in the case study

The single most defining characteristic of case study research lies in delimiting the object of study, the case (158). There is a debate in the literature as some researchers suggest that, a case study is less of a methodological choice than "*a choice of what is to be studied*" (158, 160). The "what" is a bounded system (162),

a single entity, a unit around which there are boundaries. The case can be a single person, a program, a group, an institution, a community or a specific policy. Other researchers think of the case as "*a phenomenon of some sort occurring in a bounded context*" (158, 163). Furthermore, the other one argues that the unit of analysis characterizes a case study, not the topic of investigation (158).

If the phenomenon is not intrinsically bounded, it is not a case (158). One technique for assessing the boundedness of the topic is to ask how finite the data collection would be, that is, whether there is a limit to the number of people involved who could be interviewed or a finite time for observations. If there is no end, actually or theoretically, to the number of people who could be interviewed or to observations that could be conducted, then the phenomenon is not bounded enough to qualify as a case (158). This study was limited in terms of time, places and number of people to be contacted and thus, to the extent, fulfils these criteria of case study methodology.

As it is the unit of analysis that determines whether the study is a case study, this type of qualitative research stands apart from the other types described earlier (158). Basic qualitative research, ethnography, phenomenology, narrative and so on are defined by the focus of the study, not the unit of analysis. The basic qualitative approach can be used as a broader methodology to understand the functioning of a phenomenon along with a case study approach, used to specifically investigate the cases and to interpret the functioning of the process (158). Ethnographic cases, wherein the culture of a particular social group is studied in depth, are quite common (158). In addition, one could build grounded theory within a case study, or analyse the data in a case study from a critical theory perspective, or present a persons' "story", hence combining narrative with a case study (158).

Unlike experimental, survey, or historical research, the case study does not claim any particular methods for data collection or data analysis (158). Any and all methods of gathering data can be used in a case study, although certain techniques are used more than others (158). The focus of this study was on qualitative research and so qualitative data gathering and analysis techniques were used.

Case study design has been differentiated from other research designs by what Cronbach called "*interpretation in context*" (158, 164). The decision to focus on qualitative case studies stems from the fact that this design was chosen precisely because my interest was to understand and interpret the study findings rather than a hypothesis testing. Moreover, case study focuses on holistic description and explanation (158). The design is particularly suited to situations in which it is impossible to separate the phenomenon's variables from their context (158, 159). Therefore, I found it congruent to this study because professionalism is also contextual.

Types of case studies

There are several typologies of case studies, shown in the Table 7.

Table 7: Typologies of case studies.

Yin (165) identified three such types in terms of their outcomes. • Exploratory case studies (as a pilot to other studies or research questions) • Descriptive case studies (providing narrative accounts) • Explanatory case studies (testing theories).
Merriam (166) has also categorized four common domains or kinds of case study. • Ethnographic • Historical • Psychological • Sociological
Sturman (167) has identified four kinds of case studies. • An ethnographic case study—single in-depth study • Action research case study • Evaluative case study • Educational case study
Stake (143) classified case studies into three types, differentiated by the researcher's interest. • Intrinsic (researcher intrinsic interest specifically in case) • Instrumental (researcher interest in understanding phenomenon, case has secondary value) • Collective (multiple cases are studied to investigate phenomenon or population)
Merriam (158) latter divided the qualitative case studies into three main types. • Historical and observational • Intrinsic and instrumental • Multisite case studies

These different classifications show differences in understanding of the use of case studies. They give a broad range to researchers to justify and adjust their research according to the classification and type which suits the research topic and questions. The type of case study used in this research can be fitted to all the classifications. From Yin's point of view (165), it is an exploratory case study as it is exploring a phenomenon (understanding professionalism). According to Merriam's earlier work (166), it could be regarded as a sociological case study, while her later classification (158) would consider it as an instrumental and multisite case study. It can also be classified as an educational case study if the researcher follows Sturman's classification of case studies (167).

According to my understanding of the different types of case studies, there is no sharp demarcation between different types of case studies, and in reality, case study research can use more than one type in the very same study. For example, Yin's classification of exploratory case study (165) can also have an element of description in it, while Merriam's multisite case studies (158) can also be considered as multiple intrinsic or instrumental case studies. Sturman's educational case study can have an element of evaluation in it and vice versa (167). In such a situation, one can decide the type of case study according to the thick content and the interest of the researcher. It can be categorised as exploratory if the main purpose is to explore, and most of the content is also exploratory in nature while may have some element of description. In the very same way, it can be considered as an educational case study and not an evaluative case study if evaluation was just a part of the study to assess a situation at the end or in the beginning of the study. Following Stake's classification (160), the primary interest of researchers determine whether their studies are intrinsic or instrumental depending on whether they are interested in the case or the phenomenon. This study can be considered as instrumental because my aim is to understand professionalism, and the cases are used to understand it.

The interpretations from a study can be more compelling as the number of cases increases, and also provide greater variation to understand the phenomenon under study (158). The inclusion of multiple cases is a strategy for enhancing the external validity or generalizability of the findings (158). This study collected data from

more than one case and from more than one site which makes it a multisite case study. Other terms which are commonly used for multiple case studies are collective case studies, cross-case study, multi-case studies, multisite studies or comparative case studies (158).

Strengths of a case study research

The case study methodology was useful in this study for the following reasons.

- The study design was selected based on the purpose of the study. This approach offered understanding professionalism in complex social units consisting of multiple variables of potential importance (158).
- This methodology can be used in combination with different theories which may help in expanding the unit of analysis, and hence it can play an important role in advancing the field's knowledge base.
- The multiple case studies along with a sociocultural theory are intended to provide insightful explanations from the data.
- The methodology offered an open ended approach in selecting multiple data collection and data analysis instruments, which were helpful in triangulation to ensure the validity of the data.

Limitations of a case study research

The limitations of case study as methodology are as follows.

- Multisite case studies were challenging to manage (158). Bogdan and Biklen (158, 168) have recommended doing field work on one site at a time rather than simultaneously collecting data from several sites. They argue that:

  > "The reason for this is mainly that doing more than one site at a time can get confusing. There are too many names to remember, too much diverse data to manage."

  I could not follow this advice at the individual case level but managed to do so across the countries. The data from Scotland was collected from November 2012 to February 2013, and for Pakistan, it was collected from February 2013 to March 2013.

- There was an unusual problem of ethics especially at the evaluation stage. The readers of case studies need to be aware of biases that can affect the final report (158). In this study, some negative reports about professionalism emerged from different cases, and therefore an ethical decision was made to anonymize the identity of the medical schools and the research respondents.
- Further limitations involved the lack of control of the situation. The lack of representativeness and subjectivity of the researcher brings in biases in this approach (169). However, this argument against case study research misses the point that the aim of this type of approach is to understand the complex phenomena in real world (158, 170).

Table 8 explains the properties of both qualitative research and a qualitative case study.

Table 8: Summary of the properties of methodologies used in the study.

Methodology	Properties
Basic qualitative study	• Focus on meaning, understanding & process. • Purposive sample. • Data collection via interviews, observations & documents. • Data analysis is inductive & comparative. • Findings are richly descriptive & presented as themes/categories.
Qualitative case study	• In-depth analysis of a bounded system. • Data can be collected through all instruments of data collection but some techniques are more commonly utilized.

Development of questions for data collection

The keywords for criteria of medical professionalism were identified from the selected literature, such as Tomorrows' Doctors, Good Medical Practice, and two recent papers on professionalism (19, 37-39). These keywords were linked with the initial analysis, also known as the category formation. The categories were analysed for a deeper understanding of their meaning. These categories were then arranged under themes on the basis of the situations and groups which the

respondents were dealing with. Questions were developed for the respondents around those themes to understand their thinking processes and reasoning. The process of development of initial three questions is shown in Table 9.

Table 9: Development of questions 1, 2, and 3 from the literature review.

Keywords	patient centred care, relatives and carers, honest, trustworthy, polite, dignity, privacy, confidentiality, respect, patient rights, moral and ethical responsibility, professional regulations
Category formation	• Respecting the patients' autonomy • Respecting the patient s' confidentiality and privacy • Acting in a responsible fashion towards patients • Being attentive to the needs of patients • Showing compassion towards patients. • Treating patients fairly and without prejudice • Being empathetic when caring for patients
Theme	• Patients and relatives
Interview questions to explore the theme	• Can you describe what professionalism means to you in the context of a doctor? • How do you think, a professional doctor should approach his patients? (or relatives or carers of his patients). • What is the usual practice that you observe when doctors communicate with patients? Is the practice as you expect? (Any example?).

Pilot Interview and testing of the format of questions

The study instrument was pilot tested before data collection with three faculty members from two medical schools (Case 1 & 2). These faculty members fulfilled the criteria for the sample as they were practising clinicians with experience of teaching medical students, and had an understanding of medical education. All the questions were arranged in an indirect format so as not to offend any of the respondents. The initial format consisted of 12 questions based on 35 categories from the literature (Appendix 4 in the appendix section). The average time for the interviews was between 40-60 minutes. The following changes were made to improve the format of questions, after discussing it with the respondents:

- The number of questions was increased from 12 to 16, as some of the themes required further exploration for in-depth details for example; two questions were added to explore the theme of self-regulation. Table 10 shows a set of questions that were asked from the study participants.
- The wordings in some of the questions were reorganized.

- The questions were arranged not to directly ask about cultural issues related to age, race, gender, social class and mental vulnerability in order to avoid bias and to use it as an 'informal' strategy. The respondents needed to be allowed to reflect on what they think without giving them any 'prompt' when they are replying.
- A hint or example may be given if the question is unclear to the respondents.

Table 10: Set of questions for interviews and focus groups.

1. Can you describe what professionalism means to you in the context of a doctor?
2. How do you think, a professional doctor should approach his patients? (or relatives or carers of his patients).
3. What is the usual practice that you observe when doctors communicate with patients? Is the practice the same as you expect? (Any example?).
4. What is your experience of the doctors when you were a patient? Was it the same as you would expect from a professional doctor? (Any example?).
5. How do you find doctors, when dealing with their colleagues/trainees?
6. How do they act in teams in their clinical settings?
7. How do doctors treat other health care professionals? (For example, a nurse, dentist or a homeopathic doctor, etc.).
8. Do you think doctors should regulate themselves to improve professionally? If yes, how should they do it?.
9. How do you self-regulate yourself to be a professional doctor?
10. Do you think, other doctors actually self-regulate in reality? What are the usual practices which you observe?
11. What are your views on how society regards you as a doctor/or medical student? What are their expectations of you?
12. What are your views on how your family regards you as a doctor/or medical student? What are their expectations of you? (e.g. giving medical advice to family).
13. What are the difficulties/stress that this creates for you? Can you give an example?
14. How often do you think, the doctors work within their defined professional limits and legal boundaries?
15. Have you ever felt a conflict between practising medicine and the law?
16. How do doctors resolve issues and difficult situations which may arise in their work? (For e.g. ethical situations related to patients, students, colleagues or teams and system or administration).

Selection of the sample

The two basic types of traditional sampling are probability and nonprobability sampling techniques. Probability sampling allows the investigator to generalize results of the study from a sample to the population from which it was drawn (171). Since generalization in a statistical sense is not a goal of this qualitative research, probabilistic sampling is not necessary or even justifiable here (171). Thus, this study has used the most common type of non-probability sampling technique, the purposive sample. A purposive sample is based on the assumption

that the investigator wants to discover, understand and gain an insight, and therefore must select a sample from which most of that information can likely be obtained (171).

In purposive sampling, the first step is the selection criteria for choosing the people or sites (171). The other term which is, preferably, used for purposive sampling is 'criterion-based selection' (141, 172). In criterion-based selection, the researcher must "*create a list of the attributes essential*" to the study and then "*proceed to find or locate a unit matching the list*" (141). In this study, criteria for purposive sampling was established based on the purpose of the study, and have guided the identification of potentially information-rich cases.

Types of purposive sampling

The five most common types of purposive sampling are typical, unique, maximum variation, convenience, and snowball or chain sampling (171). A typical sample is one that is selected because it reflects the average person, situation, or instance of the phenomenon of interest (171). A unique sample is based on unique, atypical, perhaps rare attributes or occurrences, of the phenomenon of interest (171). Maximum variation sampling is used where there is conceptually dense and potentially more useful data in widely varying instance of the phenomenon (171, 173, 174). This type of sampling technique was found to be congruent to the aims of this study, to understand culture of medical professionalism but it is also criticized for its "*deliberate hunt for negative*" or disconfirming "*instances or variation*" of the phenomenon (163, 171). Convenience sampling is the one in which participants are selected on the basis of convenience in time, money, location, availability of sites or respondents, and so on. Selections made on the basis of these factors may not be very credible, and they may produce information-poor cases (171). Snowball, chain or network sampling is a strategy in which key participants, who meet the criteria, are first contacted, and then invited to take part in the study (171). I have also used this sampling strategy at the start of the study when asking for reference from the initial interviewees. This strategy for sampling has been appreciated in situations of such studies which are multi-site (171). It helps in the accumulation of information which gets richer as more people are contacted (171, 174).

Sampling technique

Two levels of sampling were used in this study (171). First, 'the case' was selected, followed by sampling within the case (171). Selection criteria were established to find out which case to study and then, the cases were selected that met those criteria. For multi-case or comparative case studies, several 'cases' were first selected based on relevant criteria (171). One of the criteria was to get as much variation as possible. Within every case numerous sites existed that were visited for example, the affiliated teaching hospitals with medical schools. The second set of criteria was used to select the samples within the cases. Thus, two criteria are required for two levels of sampling in multiple case studies (171). In both levels, maximum variation and snowball sampling techniques were used.

Level 1: Selection of the case

Criteria

- A well-established public or private sector medical school.
- Three medical schools from a developed liberal Western country, Scotland, and three medical schools from a developing conservative Eastern country, Pakistan.
- Medical Schools far apart and located in different cities to give maximum variation.

Level 2: Selection of sample within the case

Group 1: 5-10 Faculty members from each medical school (Semi-structured interviews)

Criteria

- The participants should have good understanding of Medical Education, and preferably be drawn from different specialities to give maximum variation in experiences.

- Two clinical faculty members from one Scottish medical school (Case 2) had worked across both Pakistan and Scotland.
- The demographic details for the faculty members from Scotland and Pakistan are given in table 11.

Table 11: Demographic details of faculty members from Scotland and Pakistan.

	Scotland			Pakistan		
	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
No. of faculty members	5	5	5	9	6	6
Gender						
Male	4	4	2	8	5	4
Female	1	1	3	1	1	2
Age (Yrs)						
40-50	0	3	3	2	2	4
50-60	5	2	2	7	4	2
Nationality						
Scottish	5	3	5	0	0	0
Pakistani	0	2	0	9	6	6
Speciality						
GP	3	2	1	1	1	0
Medicine	0	2	1	0	2	0
Endocrinology	0	0	1	1	0	0
Rheumatology	1	0	0	0	0	0
Oncology	0	1	0	1	0	0
Paediatrics	0	0	0	0	1	0
Psychiatry	0	0	0	1	0	0
Dermatology	0	0	0	1	0	0
Surgery	0	0	2	2	1	4
Gynae & Obs.	0	0	0	0	0	1
ENT	1	0	0	2	1	1

Group 2: 7-10 Medical students (Focus group discussion)

Criteria

- Year 4 medical students, preferably 4 male and 4 female.

Why 4th Year students?

- They can reflect on their near past experiences as young students.
- They are exposed to clinical rotations and have a good experience of dealing with patients.
- They can be easily accessed as compared to 5th Year students.

Why 4 male and 4 female?

- To eliminate gender discrimination in a conservative Asian culture.

- To investigate any emerging differences in understanding professionalism due to gender factor.
- This criterion, although considered, could not be achieved in two medical schools in the UK because the participation was volunteer based. In the FGD with Case 1, only 2 female students participated while in Case 2, only one male student volunteered for the FGD.
- The demographic details for the students from Scotland and Pakistan are given in table 12.

Table 12: Demographic details of students from Scotland and Pakistan.

	Scotland			Pakistan		
	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
No. of students	7	7	9	8	10	10
Gender						
Male	5	1	4	4	5	5
Female	2	6	5	4	5	5
Age (Yrs)						
21-24	7	7	9	8	10	10
Year of study	Year 4	Year 4	Year 3	Year 4	Year 4	Year 4
Nationality						
Scottish	6	7	5	0	0	0
Pakistani	0	0	0	8	10	10
Middle East	0	0	2	0	0	0
Singapore	1	0	1	0	0	0
US	0	0	1	0	0	0

Data collection methods

I have used two data collection instruments for two different groups of respondents, depending on the feasibility, purpose and my experience to use them. The clinical faculty members were interviewed on a set of open-ended questions while the students were requested to attend a focus group discussion, to which they agreed. The discussion in the focus group was again guided by the questions which were developed from the literature review. The data collection instruments are further discussed under their relevant headings.

Semi-structured interviews

Among the three types of interviews, unstructured, semi-structured and structured formats, I have used the format of a semi-structured interview due to its suitability to this study (142). The first reason to use the semi-structured interview was the rationale of this study, to explore different themes of professionalism in local contexts through a qualitative study (19, 33). Sixteen open ended questions were developed around 35 categories from the literature, grouped under 9 themes (19). These questions could only be explored to understand the reasoning behind them, through the semi-structured format of the interview, and so, that was congruent with the purpose of the study. It is important to establish rapport with the interviewee and to probe some issues which the interviewee has raised during the interview (145, 175).

The second reason to use the semi-structured interview was to protect the privacy of the faculty members. Senior clinical faculty members from all six cases were contacted and steps were taken to ensure their privacy and confidentiality (142). All the interviews were conducted one to one, either in an office or in a separate reserved room. It is also recommended in the literature that interviews should occur with key members of the organization because of their holistic view and insight into the issues (142). Due to this reason, these interviews have also been named the “elite” interviews because most of the senior clinical faculty members were at the position of the Principal, Dean, Head of Department, Clinical Leads or Senior Consultants (142).

The third reason for using an interview technique was my familiarity with the protocols of interview from prior experience of my Masters’ research, and with audio recording and transcription of interview data. The fourth reason was economical and related to the time factor. It was necessary to organize multiple visits across five cities in two countries and had to respect the limited availability of the respondents. This interview technique enabled me to collect the data over a period of five months.

There is some criticism of semi-structured interviews. They may be considered as a weak data collection instrument as compared to unstructured interviews because

they may not yield an adequately deep insight about the topic under study (142). It is clear from the literature (141, 145, 175), that the type of interview format depends on the purpose of the study. The semi-structured interview format has enabled me to follow the format of investigating the themes of professionalism despite the time constraint for follow-up and probes. It has also given me an in-depth understanding of the theme under discussion, while considering the local context (145).

One of the difficulties with semi-structured interviews in this multi-site study was the geographical and cultural factors. The difficulties were in identifying and meeting people. This was facilitated by using professional networks. Cultural influences on data collection were reduced because of my multi-cultural background.

Focus group discussions (FGDs)

It is pertinent to explain how a focus group is different from similar techniques. A focus group is defined as, "a group discussion organized to explore a specific set of issues" (176). These groups are focused in that they are engaged in some collective activity (177). In this respect, they are different from similar techniques such as, a 'nominal group method' in which the members of the group are multiple stakeholders and so the discussion may not be focused on some specific themes (178). The participants of focus group (FGDs) can raise issues according to their interests and the discussion is interactive. Focus group discussions (FGDs) are different from the focus group interviews in which the researcher asks the same question from each group member individually, and in which there may be no interaction or discussion among group members (141).

The decision to select focus group discussion as the second data collection instrument was again based on the:

- purpose of the study
- my expertise
- time frame
- feasibility as a data collection instrument

I facilitated six focus groups, one from each medical school with a group of 7-10 students from Year 4. All the focus groups were audio recorded and later transcribed using 'Transcriber Software'(179). The first reason for the use of focus group in this study was its purpose. Due to the complexity of the topic, I found this data collection instrument useful because the experience of students was naturally more limited than that of faculty members and the discussion helped in the development of a debate. The format was that any one student would throw in an idea which would help in further discussion and might help others to offer counter arguments to the initial idea. This helped in looking at the themes of professionalism from different perspectives and gave a deep insight into participants' understanding of the topic. The second reason was my expertise with the facilitation of group discussion with a small number of students. I have been a PBL facilitator for the last five years, and have also attended courses on PBL facilitation and workshops on focus group discussions that have equipped me with facilitation skills in such group discussions. Finally, the time frame and feasibility of FGDs was acceptable. The data was collected from multiple students in a time frame of 60-90 minutes, and in one single setting from within one medical school. A further advantage in all the FGDs was having a focal Member of Faculty, from the respective medical school, who helped in recruitment of the students for FGD, organized the rooms, and arranged the food for the students.

There were also some difficulties with FGDs, including contacting the students either directly or indirectly, through a faculty member of the respective medical school. The recruitment and ensuring the students' presence on the day of the FGD, was a time consuming task. The students were given two incentives to ensure their presence. The first was to provide lunch at the end of the FGD and the second incentive was a 'certificate of participation in a research activity'. These incentives were mentioned in the ethics application and approved by the ethics committee. Another difficulty was with the transcription, and at the analysis stage, as these were considerably more time consuming than the interviews.

Data analysis techniques

The data was analysed manually using a thematic analysis technique. Software such as NVivo was considered for data analysis but my previous experience with its use in the Masters' dissertation suggested that this software was largely useful only for data organization purposes. In this study, I had organized data files in specific folders and subfolders. The central analytical task in qualitative research is to understand the meaning of text which is analysed by the researcher, and not by the software (180, 181). Moreover, the options and format of NVivo were limiting my critical thinking and so I preferred to analyse the data manually from the transcripts.

Thematic analysis

Thematic analysis is a method of data analysis in which a pattern, a finding, or an answer to a research question is identified (182). This method of qualitative data analysis allows recognition of data at contextual, descriptive, and analytical levels. Thematic analysis is inductive in nature at its initial stages in which there is a discovery of different phenomena but, at the later stages of analysis, it becomes deductive by using the method of constant comparison to identify commonly recurring patterns in the data (142, 145, 182, 183).

Before going into further details, some of the terms which will be repeatedly used in this study, such as code, category, theme and memo, will be explained. After that, there will be a description of the cycles of coding, types of coding, and strategies for making themes.

Code: A code can be defined as, "a word or short phrase that symbolically assigns a summative, salient, essence capturing, and/or evocative attribute for a portion of language-based or visual data" (184). There are more than thirty different types of codes and it is not necessary to use all of them with one single data set (185). In some cases a code may not suit the research question or may not be congruent with the methodology of the study (185). In the same way, one study may use up to

ten different types of codes with a single data set (185). Some analytical approaches, such as the discourse analysis, may not use any codes at all (185).

Category: In this study, the category is defined as *an organization and grouping of similar codes, based on some shared characteristics under a term* (186). The term might be a word or a sentence which reflects the characteristic of the codes (186). It is also used in parallel with the word 'codifying' because, "*to codify is to arrange things in a systematic order, to make something part of a system or classification, to categorize*" (186). A category can become a sub-category during the second cycle of data analysis (186).

Theme: A theme, in simple terms, is defined as "*an outcome of coding, categorization, and analytic reflection, not something that is, in itself, coded*" (187). It can be explained as a phrase which informs us what the data is about and tells us what it means (187). A theme identifies the data at two levels: the 'manifest level', that is, the direct observation and description of the data, and the 'latent level' in which it explains the underlying phenomena in action (188). At the latent level, there is an element of pre-reflexivity in a theme at a point where the researcher has not yet taken a stance and is still trying to understand the data. In general, a theme is a form of capturing a phenomenon (189).

Thus, both codes and categories were based on 'words or phrases' but the difference was in the hierarchy of understanding. The 'words or phrases' of categories were at a superior level of interpretation. Moreover, a category was covering more than one code or, in other words, with many codes providing a foundation for one category. The same hierarchy was followed with themes and categories. Multiple categories were selected and grouped together on the basis of information which they were providing that contributed towards understanding of a theme.

Memo: A memo in qualitative research is a 'note' by the researcher, based on observation or experience during the study (190). These notes may explain a phenomenon or a process under investigation (190). Memos can be understood as sites of conversation with data in which researchers either think about a code or a category, about what they mean and about how that meaning might be related to

other factors (191). In this study, this thinking helped towards a deep understating of the data in reflections noted down as memos. The purpose of memo writing is to invoke the researchers' reflexivity and critical thinking about the data and to look at how data relationships are formed and affect each other (190). Memos were helpful whilst comparing them to the data and in analysing areas in which they were either conflicting or consistent with the data. I regularly updated these notes and found them helpful in the discussion of the results.

Cycles of coding

The coding was done in three cycles. Three cycles means to analyse the whole data three times. The first cycle codes ranged from single words to sentences or entire paragraphs while in the second cycle, the codes were exactly the same units, or they encompassed longer passages or they rephrased the previous codes. The third cycle of coding was done to ascertain cross-case results using a constant comparison method. The cycles are explained further below.

First cycle of coding

The first cycle of coding is the method which takes place during the initial analysis of the data. There are more than twenty coding processes that can be used in the 1st cycle of coding, depending on the requirement of a study (192). In this study, only eight different types of codes have been used to interpret the data. There were also some codes which were overlapping and, for that reason, this cycle is also known as a "mixed and matched" approach (192). For example, a single code can be both 'holistic' and 'descriptive' as further explained in their relevant sections.

Types of coding methods used in the first cycle of coding

The eight different types of coding methods used in the 1st cycle of coding are as follows.

i. Attribute coding
ii. Holistic coding
iii. Descriptive coding

iv. In Vivo coding
v. Initial coding
vi. Values coding
vii. Emotion coding
viii. Versus coding

i. Attribute coding

This is coding at the beginning of the dataset, rather than embedded within the data (192). This type of a code provides descriptive information about the participant of the study, such as the medical school in this study to which s/he belongs and the group, which group s/he is drawn. The attribute coding is used for ethical reasons so that no-one else can recognize the true identity of the study respondents, other than the researcher (192). For example, 'IK FP3 C2', in which the first two alphabets 'IK' are the initials of the name of the respondent, 'FP3' means 'Faculty Participant number 3', and 'C2' is the initial for 'Case 2' or second medical school. This code is used to manage the whole dataset and was later used to identify participants for comparisons.

ii. Holistic coding

Holistic coding is an exploratory coding method used at the start of analysis when other more refined codes have not been made (192). It is based on a large unit of data to give an overview of the transcript before proceeding to the more sophisticated coding techniques of the 1st, 2nd, or 3rd cycle of coding (192). There are no specific length restrictions on this coding type and the code may range from half a page to the whole transcript (192). The holistic codes may help towards the formation of the categories and theme (192). In this study, an example of a holistic code was 'self-regulation', which was based on a data set covering three pages and was embedded across three questions.

iii. Descriptive coding

Descriptive coding, also known as 'topic coding', is either a word or a short phrase which usually does not come from the text but from the researchers' understanding of the text and the way in which the text describes the phenomena under study

(192). It is important to note that this type of code describes the topic, that is, what is discussed, not the contents (192). Example of descriptive code is, influence of healthcare system on medical professionalism.

iv. In Vivo coding

This type of code, also known as 'literal coding' or 'verbatim coding', is taken directly from what the participant has said, and is usually placed in quotation marks (192). It may be a word or a short phrase that the participant has said in the interview, or in the FGD. This coding method is important for ethnographic studies where the focus is on cultures or sub-cultures and there are specific words which have their own meaning within that culture (192). Although this study is not ethnographic, there are two reasons for the use of this coding method. The first is that this study was carried out at multiple sites so the respondents were from different cultures. The second reason was the congruence of this coding method with CHAT. This coding method helped in the discussion where the data was looked at from the perspective of CHAT. An example of this coding is the word "protocol", which was commonly found in the transcripts from Pakistan because of the 'protocol culture' there but it was not so common in Scotland.

v. Initial coding

Initial coding, also known as 'open coding', is breaking down qualitative data into discrete parts by closely examining them and comparing the data for similarities and differences (192). In the first cycle they are called 'open codes' as the researcher is open to anything that comes up from the data and to whatever direction it takes place (182). This coding technique does not have any specific formula but has an open-ended approach towards the data with some general guidelines (182). The initial coding can employ In Vivo or descriptive coding using codes based on observable activity and actions (192). Assigning codes to the pieces of data helps to build categories or themes (182). The use of this coding method in the first cycle of data analysis helped in the description of the data. Examples include practices different from theory, variation in views about other healthcare professionals, and interacting with colleagues.

vi. Values coding

Value coding is used to indicate the values, beliefs, attitudes, behaviours and attributes of the participants (193). It can show their perspective of how they see the world (193). *"A belief is part of a system that includes our values and attitudes, plus our personal knowledge, experiences, opinions, prejudices, morals, and other interpretative perceptions of the social world*" (193). These codes were considered as guiding one's values, thus guiding attitudes and behaviours. An example is at the level of spiritual/religious or non-spiritual/non-religious beliefs. A 'value' is *"an attribute to oneself, another person, thing or idea"* (193). A value has both internal and external motives and can be considered as a guiding principle for attitudes (194). An 'attitude' is *"the way we think and feel about oneself, another person, thing, or idea"* (193). Attitudes are considered as part of *"a relatively enduring system of evaluative, affective reactions based upon and reflecting the evaluative concepts or beliefs, which we have learned"*(195).

In this study, behaviour is understood as 'observable action or activity'. This observable action could either reflect the attitude of the respondents or it could also mask it (66). The 'attribute' is a 'behaviour in context' (38). For example, how a doctor shows 'empathy' towards patients in the ENT ward in a morning ward round and how it is reflected in the situation of an ENT OPD with 100 patients. The behaviour for empathy may also change from a public hospital setup to a private clinic setup, or it may change from patient to patient even within the same ward or same OPD on the same day. Figure 12 shows the guiding principles from beliefs to attributes. The Figure shows that beliefs are internal to an individual, while behaviours and attributes can be seen by the external world. The arrow on the right side of the Figure shows the guidance, influence, and relationship of beliefs to attributes scheme.

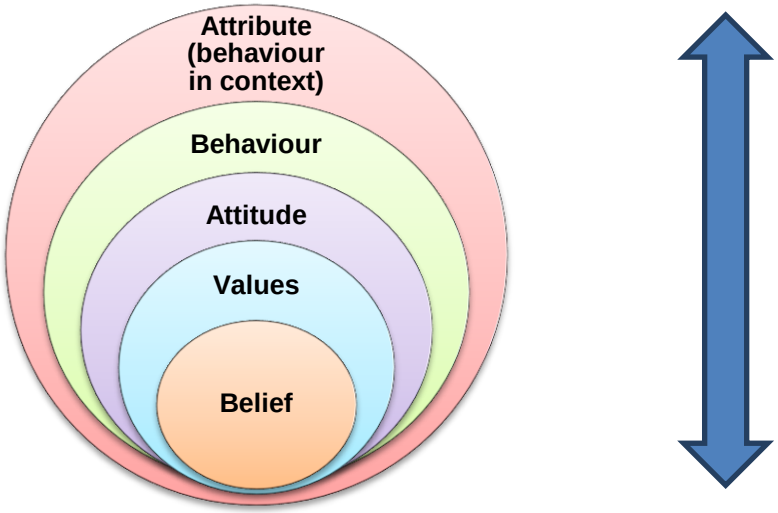


Figure 12: Value coding scheme used in this study.
Beliefs are internal to an individual, while behaviours and attributes can be seen by the external world. The arrow shows the guidance and relationship of belief to attribute system. Original diagram, compiled from information in Homer and Smith (194, 196).

This coding method helped in exploring the cultural values, and intra- and interpersonal experiences and actions of participants (193). In this study these codes were used to analyse the perspective of respondents about professionalism and to understand whether they see professionalism at behavioural, attitudinal, value, or belief level. An example of the value code from this study is 'Values define professionalism', which came from one of the interviews with a faculty member from Scotland (Case 1).

vii. Emotion coding

Emotion coding was based on the experiences of the respondents (192). These codes were particularly helpful in exploring the intra and inter-personal experiences and actions of the respondents (192). The respondents shared their stories and experiences of professionalism which led to codes, such as "uncertainty", "anxiety", "cautious", etc.

viii. Versus coding

A Versus coding technique was used where there were conflicting ideas, either between two respondents or organizations or cultures (192). The technique was mostly used in the analysis of FGDs when the students were not agreeing on some specific point such as 'the role of external regulation in self-regulation'. The same coding technique was also used among interviews across multiple cases where

there were varying views about the role of an external regulator and how it is influencing internal regulation.

The Versus code is also known as 'rival explanation' in multiple case study research (142). The Rival or Versus codes lead to rival hypothesis or possible explanations (142). If these rival explanations do not fit together, they lead to rejection of one argument and strengthening of another claim (142). The example of a rival explanation came from one of the FGDs in Pakistan in which students were discussing 'the approach of doctors towards patients'. The students shared the experience of an ENT OPD where two doctors were running the same OPD with a high number of patients. One of the doctors became aggressive with patients due to workload however the other doctor was calmly providing consultation to the patients. The point of discussion was why patient-overload was apparently adversely affecting only one doctor's mood. After some discussion, the students finally reached the consensus that, in general, patient-overload negatively influences the mood of some doctors but not others and that might depend on the individual personality traits of the doctor. Some doctors will be able to stay calm and polite within an overloaded OPD.

Inclusion criteria for themes

The rule for inclusion in a theme takes the form of a proposition (192). The inclusion criteria can refine the content of a category (working within) before comparing categories with each other (working across) (192). These propositions can be either descriptive or conceptual in the 1st cycle of data analysis (192). Example of a theme from the 1st cycle is given below.

Self-Regulation: The participant shared how they self-regulate through reflection, control, responsibility, and self-assessment. For example, *"I reflect on my daily practices when I go to bed at night before going to sleep"* (SA FP3 C5), and *"Throughout my life, I have learned through self-assessment"* (IAS FP5 C5).

Second cycle of coding

The second cycle of coding was more challenging than the first because there was more conceptualizing, theorizing, and abstraction required at this level so as to understand professionalism in the context of CHAT and also to build a theory (192). Here, 'building the theory' means the formation of a theme and its explanation and interpretation by linking it to 'within data' or 'outside data' concepts, so as to cover any missing links (192). At this point, CHAT has helped in giving the dimensions to understand and build a theory. Thus, a theory, that is, CHAT, has helped towards the formation of another theory, in the form of themes, though at minor level.

The second cycle of coding has provided a hierarchal structure to the data. It was not perfect but it has facilitated the combination, mixing, and filtering of some of the categories from the first cycle (193).

Types of coding methods used in the second cycle of coding

The second cycle of coding can become easier if the first cycle of coding is done carefully (193). There are six different types of coding techniques in this cycle but only four were used in this study, outlined below (193).

i. Pattern coding
ii. Focused coding
iii. Axial coding
iv. Theoretical coding

i. Pattern coding

Pattern coding has helped in developing the 'meta-code', by providing a framework to attribute meaning to a particular organization of categories (193). These are also called explanatory or inferential codes and they have helped in identifying emergent themes in a more meaningful manner (193). The term 'meta-code' means that this coding groups together in smaller categories (193). They are different from 'focused coding' (explained later) because the emphasis here is on the conceptual inference or explanation made from the code, not on the basis of expression similarity which will be discussed in the focused coding section (193).

This type of code can be applied in the 2nd cycle of coding and, in addition to thematic analysis, pattern coding can also be used in content analysis, grounded theory, situational analysis, and action research (193).

ii. Focused coding

This coding technique, as evident from its name, helped in categorizing the data based on thematic or conceptual similarity (193). The focus was on 'how similar' codes were, and not on the interaction or relationship which is the hallmark of axial coding (193). The former stages for this type of coding techniques were In-Vivo and initial open coding (193). Therefore the similarity of codes is in the form of 'expression similarity', where the same tribes (categories) were organized under a focused code, such as the categories of facilitator, assessor, teacher, clinician, under the focused code of 'roles'.

iii. Axial coding

The grouping of categories and codes on the basis of relationships and interactions is called axial coding or analytical coding (197). The axial codes have given a more in-depth understanding to the meaning of the data (182). This type of coding has reflected on the dimensions and properties of categories and explored how the categories and subcategories were interconnected (193). The former stages for this type of coding technique were In Vivo and initial open coding. These codes were not only looking at the relationships of the first cycle of coding, but they also provided a framework to comment on the relationships of the focused codes which were part of the second cycle of coding (shown in the Figure 13). There can be one or more than one axial codes formation in a study (193).

iv. Theoretical coding

Theoretical coding, also known as selective coding, has assisted in discovering the central categories that contributed to the primary theme for the study (193). These codes function as an umbrella, covering all the first and second cycle coding and are also known as the central or core category in grounded theory (193). This consists of all the products of analysis condensed under few words that explains the whole project (193). This coding technique has the greatest explanatory relevance

for the phenomena, and can be considered as a well-developed proposition (193, 197). The former stages for this type of coding techniques were In Vivo and initial open coding from the first cycle and has focused, axial and pattern coding from the 2nd cycle of coding. The reflective analytic memo writing helped in both codes and category generation in the 2nd cycle of coding. An example of the theoretical code is the 'influence of healthcare system on medical professionalism'.

Inclusion criteria for themes

The 2nd cycle propositions were 'outcome propositions' unlike the 1st cycle propositions which were either 'descriptive or conceptual'. These 2nd cycle propositions have emerged by combining older themes, based on their relationships. Figure 13 presents the hierarchy of codes and the relationship of different types of coding techniques from 1st and 2nd cycle of coding.

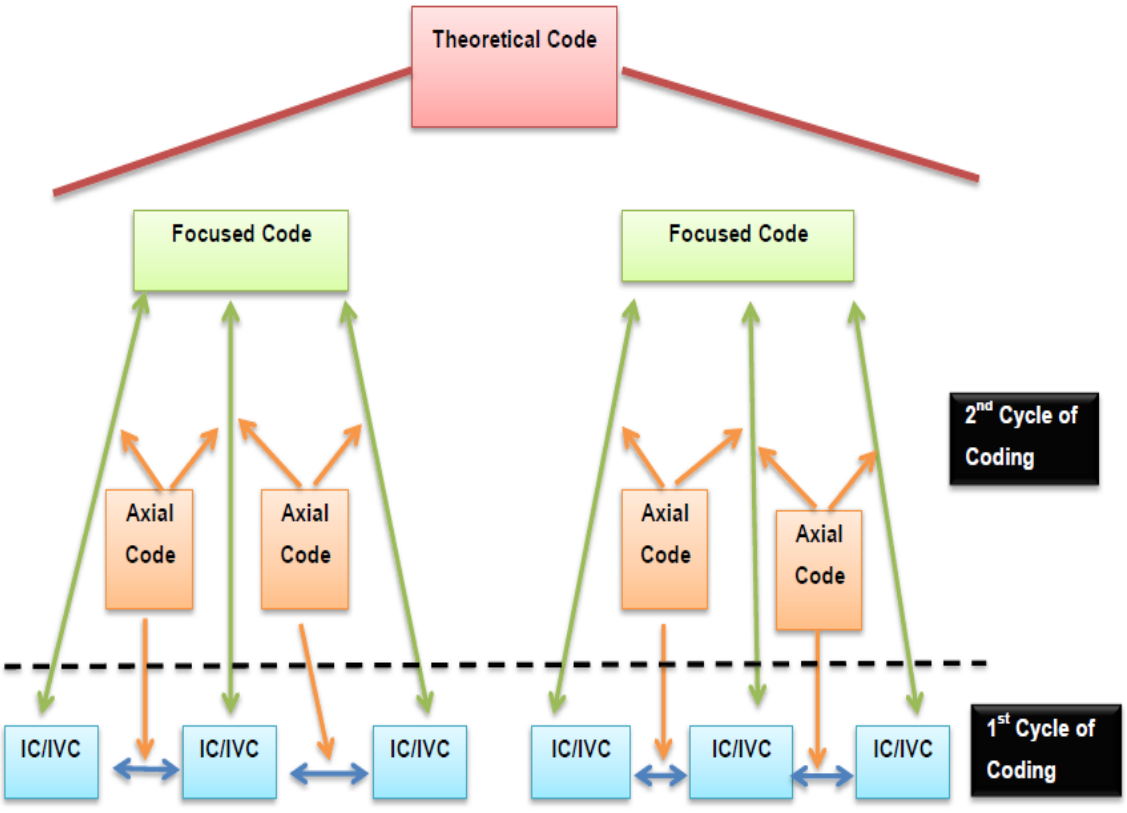


Figure 13: A scheme for the hierarchy of codes.
A horizontal black dotted line shows a demarcation between the 1st and 2nd cycles of coding, and how they are interrelated to each other. (IC=Initial Codes, IVC=In Vivo Codes)

Third cycle of coding (Coding specific to multiple case study)

The third cycle of coding was used for cross-case results using a constant comparison method (145). The constant comparison method has two parts (145). The first part is going through the data again and again, the 'constant' part, and comparing each element with other phrases, sentences or paragraphs is the comparative part (145). The basic aim is to capture a theme which can summarize the essence of the data (145). Often, the 3rd cycle of coding is not required or undertaken in a qualitative study (145). However, due to multiple cases in this study, the method of constant comparison was deployed to identify a core theme.

Coding specified to theoretical framework (CHAT)

This study has used CHAT to support the coding stage of the data. The theory provided a framework to analyse the data, also known as the framework analysis (147). The unit of analysis of CHAT has seven important components linked to each other in the form of a triangle.

i. Tools
ii. Subject
iii. Object
iv. Rules
v. Community
vi. Division of labour
vii. Outcome

During the coding process, the data was carefully analysed for patterns which were suggestive of these seven concepts and these were coded accordingly. The analysis of data from this perspective has helped in all three cycles and levels of coding, and suggested some strong, evidence-based points for the discussion of the results.

Strategies for making themes: From codes to themes

Two strategies were used to develop themes from the data (198). The first strategy was to add verbs, such as "means", "is", etc. after the phenomena under investigation (198). The second strategy was to re-read the text and to reflect on the data categories for that specific code, thus providing a more practical way of

writing (198). For example, a word ‘define’ was placed after the code for ‘Values’ and in this way it became, “Values define…”. Now the second strategy was applied and the text was read once again to search for the context. Here the interviewer was talking about ‘professionalism’, and so, the code “Values” turned into a category, that is, “Values define professionalism” which, later on, became a theme.

Data Saturation

During the initial analysis of this study, different categories were formed, which were further examined and some became sub-categories. Some categories were even removed from the final analysis, according to the interpretation. The category formation was stopped after no further new themes could be identified from the remainder of the data. This is called data saturation, a concept borrowed from grounded theory (199, 200). A memo was written based on every theme and these were continuously updated with recurring patterns seen in other transcripts, until the point of saturation. All the memos were saved in MS Word files within the folders, and given the names of the themes, so as to keep track of the relevant data. Figure 14 presents the use of data analysis technique.

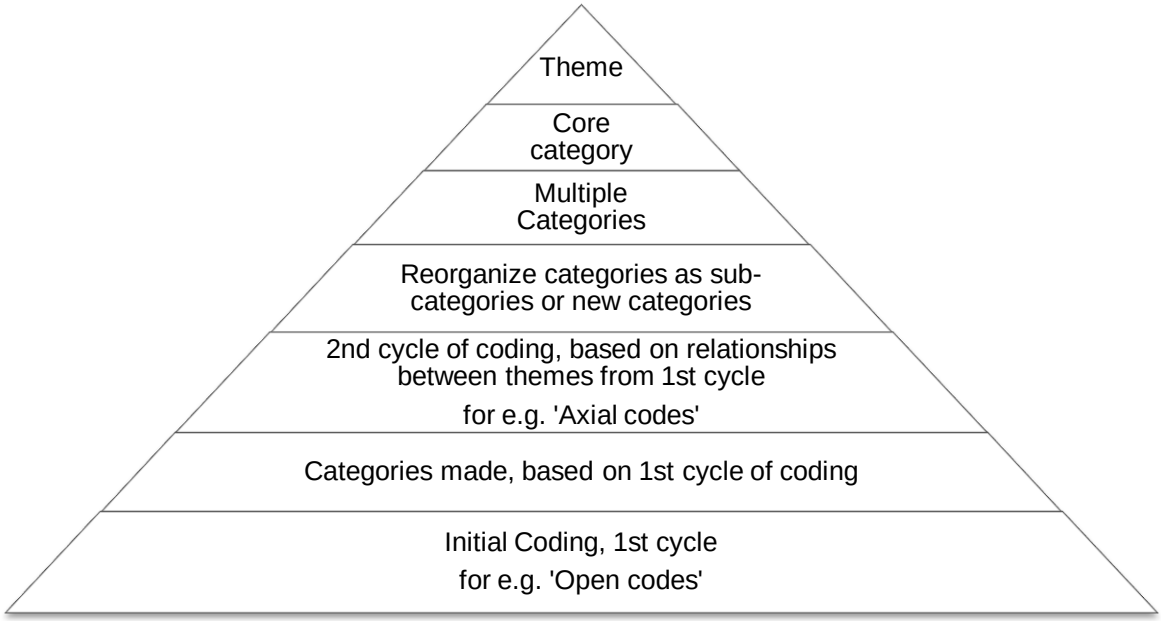


Figure 14: Schematic presentation of the data analysis technique

Quality of the study

The four main quality assurance criteria in qualitative research are credibility, transferability, dependability, and confirmability (144). The use of these criteria in this study is discussed below.

Credibility and Transferability (Validity)

In qualitative studies, the terms often used in place of validity are 'credibility' and 'transferability' (144). Credibility is similar to the internal validity of the data while transferability is used for the external validity (144). The credibility and transferability of the data has been assured by using the following methods.

Triangulation

Triangulation is a technique in qualitative research in which two or more methods are used to check the results from the data and it can also be known as cross-examination (201). The term is widely used in qualitative research but has different interpretations ranging from its rigour towards research to its open criticism (142). Some researchers suggest implementing triangulation as its name suggests, to use at least three data collection instruments to validate results (142). Others disagree to use triangulation and suggest methods such as, peer debriefing, respondent validation, and constant comparative method to validate the results (145, 175). The literature recognizes triangulation at two levels, between two methods and within a method by using more than one data collection tool (152). My understanding of triangulation is that, it is not limited to the inter- or intra-methodological levels, but it can be used at several levels to validate the findings from the study and so it has been used in this study at the following levels.

- At the methodological level where two qualitative research methods were used to facilitate the understanding of each other, that is, the basic qualitative research and the case study methodology.
- At the sampling levels where data was collected from two different groups, the clinical faculty members and clinical year medical students.
- At the cultural level, where two diverse cultures, Scotland and Pakistan were studied to understand medical professionalism.

- At the case level where six cases were compared to each other, within and across the countries.
- At the data analysis level, where three cycles of coding were used with twelve different coding techniques.

Other methods used for validation of data

The other methods used for validation of data included:

- Peer debriefing: The respondents were briefed about the topic, process, aims, and methodology of the study (144). This was done at two stages, at the initial invitation stage for participation in the study through email, and then just before the start of the interview or the focus group discussion.
- Respondent validation: The transcripts were sent back to the interviewees to check their contents (144, 175). Focus group discussions could not be sent for respondent validation because of the context specific answers given by the students and the data, if sent separately, would have lost its meaning. I myself re-checked the transcripts during the data analysis stage while listening to audio recordings and reading through the transcripts. Replies were also not received from a few of the interview respondents and I acknowledge this as one of the weakness of the validation process.
- Constant comparative method: The constant comparative method, which was used while analysing the data (144, 175).
- Protocols: Appropriate tabulations for codes and protocols were followed for each step during the data collection and analysis stage (Appendix 2) (144, 175).

Dependability and Confirmability (Reliability)

The two terms commonly used instead of reliability in qualitative studies are, ‘dependability’ and ‘confirmability’(144). Dependability refers to the replicability of the findings if there are similar circumstances in other places. The word ‘confirmability’ has been derived from the positivist paradigm, and is used to explain the notion of inter-subjective agreement within the study (144). The transcripts were compared for with each other for inter-subjective agreement. The reliability of the data was ensured by using an inter-rater reliability method.

Workshop in Pakistan for inter-rater reliability

One of the requirements of coding of qualitative data is a second member check of the data, to see if the second researcher will come up with the same codes as the first (193). This is considered an important step in establishing inter-rater reliability. The requirement is that both researchers need to have the same level of understanding about the coding schemes so that they are at the same level of knowledge. Achieving this type of reliability was difficult in this study because I had no one else with whom to code four hundred pages of data. Moreover, the same level of understanding of qualitative data analysis was also difficult to achieve. However, I did compare 10% sample of my data by facilitating a workshop in Pakistan. I facilitated a two day workshop on qualitative data analysis in which 30 faculty members from one of the local University (Case 6) participated. The workshop included 16 clinicians on the first day and 14 medical faculty members on the second day of the workshop. The duration of the workshop was four hours each day in which the participants were shown how qualitative data could be analysed. In this way, all workshop participants were standardized with the same level of exposure. Then, I distributed the anonymised transcribed interviews amongst the workshop participants so that they could code them and devise themes from them.

The transcribed interviews could not be identified back to the study participants as their personal and institutional identities were coded. The transcripts were also collected back from participants at the end of the workshop in order to later compare their coding to my coding. I had not transcribed all the interviews at that time, so only 6 interviews were distributed among the workshop participants. During the exercise, I helped the workshop participants in the formation of codes, categories and themes, which they then presented at the end to other participants. The codes of the workshop participants were useful, and I later compared them with my coding list.

The issue of reflexivity in Interpreting qualitative data

One of the key issues which arise while interpreting qualitative data is that of 'reflexivity'. The Oxford dictionary defines being 'reflexive' as '*taking account of itself or of the effect of the personality or presence of the researcher on what is being investigated*' (202). Reflexivity has many definitions and has many different approaches according to the understandings of different researchers (203). Archer defines reflexivity as '*The regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa*' (204). This is how the social scientist sees reflexivity, though some theorists do not agree and express their concerns about potential bias in the data collection, analysis, and interpretation stages (155). In medical education, some important literature has a significant element of reflexivity based on personal experiences (49). Moreover, now-a-days' most training in medical education is assessed through 'reflective portfolios' which follow the principle of reflexivity. One way to authenticate portfolios is to provide evidence from the literature and indicate how that has helped develop the thought process of the student.

The two broad levels (or types) where reflexivity can be observed in a study, are the personal and epistemological level (205). At the personal level, reflexivity refers to how the values, beliefs and experiences of the researcher influence his/her study (205). At the epistemological level, we consider how knowledge has been created and how it will influence the findings of the study (205). Reflexivity is mostly related to the postmodern paradigm (155, 206) but it can also be used, and taken as an advantage, while constructing the 'reality' in the constructivist paradigm. Bias can generally be controlled by two methods. The first is triangulation, which has been explained, and the second is by being explicit about the personal and inter-personal experiences in specific circumstances (207). In this way, the reader of the study will be able to identify and differentiate the personal views of the researcher and that of the study respondents, and it will allow some control of bias (155, 207) .

The element of reflexivity is also a part of CHAT (1, 206) where the unit of analysis consist of the subject, the object, the community, the rule and tools, and the division of labour. One can observe that learning, in case of CHAT, is dependent on both internal as well as external stimuli (1). With such a broad unit of analysis, and to comment on the learning and development of professionalism, it was necessary to be reflexive so as to give a thorough explanation of both the phenomena and the environment in which the phenomena were taking place. The triangular model of CHAT in itself controls the bias of reflexivity by using comparisons, yet gives some space for its use, so as not to miss important relationships. Therefore, I have used reflexivity in a balanced and controlled manner, balance being provided by the theory, and control by the method of triangulation and being explicit about my views.

Chapter summary

In this chapter, the use of the interpretivist or constructivist paradigm and why it was suitable for this study has been discussed. The approach has helped in constructing 'reality' from the views of the respondents. The general methodology used in this study was a basic qualitative research and multiple case studies were used, as a specific methodology, for a deeper understanding of the medical professionalism in cultural contexts. Some further concepts, related to case study research such as, sampling techniques, type of analysis, the quality in case studies, and the issue of reflexivity have also been outlined in this chapter.

The qualitative case study can be a rigorous methodology in terms of validity and reliability, which, in qualitative research, may be more usefully understood as credibility, transferability, dependability and confirmability. In this study, the technique of triangulation was used to validate findings. Some other techniques used to ensure the quality of the data included respondent validation, by maintaining protocols for all the steps of methodology, and peer review of the codes with a sample of data transcripts.

The study has used purposive maximum variation and snowball sampling techniques at two levels. In the first level, cases were selected while in the second level, samples from within the cases were selected. Six medical schools with their affiliated hospitals from 5 cities in two different countries were contacted. The questions for interview were developed from the themes that were identified from the literature to explore the issues of professionalism in detail. The study has included data collection from two groups. Clinical faculty members were interviewed (5-10 in number) from each medical school, and focus groups were organized with students from Year 4 (7-10 in number).

The thematic analysis for multiple case studies was completed in three cycles. In the first cycle, the data gave an overview of the potential themes which are further refined with the 2nd cycle of analysis. The 3rd cycle helped in identifying the commonalities among all the six cases by using a constant comparison method. Twelve different types of coding techniques were used in the first 2 cycles of data analysis. The data was interpreted by comparing it to the memos, and personal

observations that were written throughout the data collection and analysis stages. The triangular model of CHAT was an additional help in interpreting the data from different angles. It provided a framework for the unit of analysis (bounded system) of case study. The overall methodology helped in understanding professionalism in the cultural context. Figure 15 on the next page, shows an illustration of the study design.

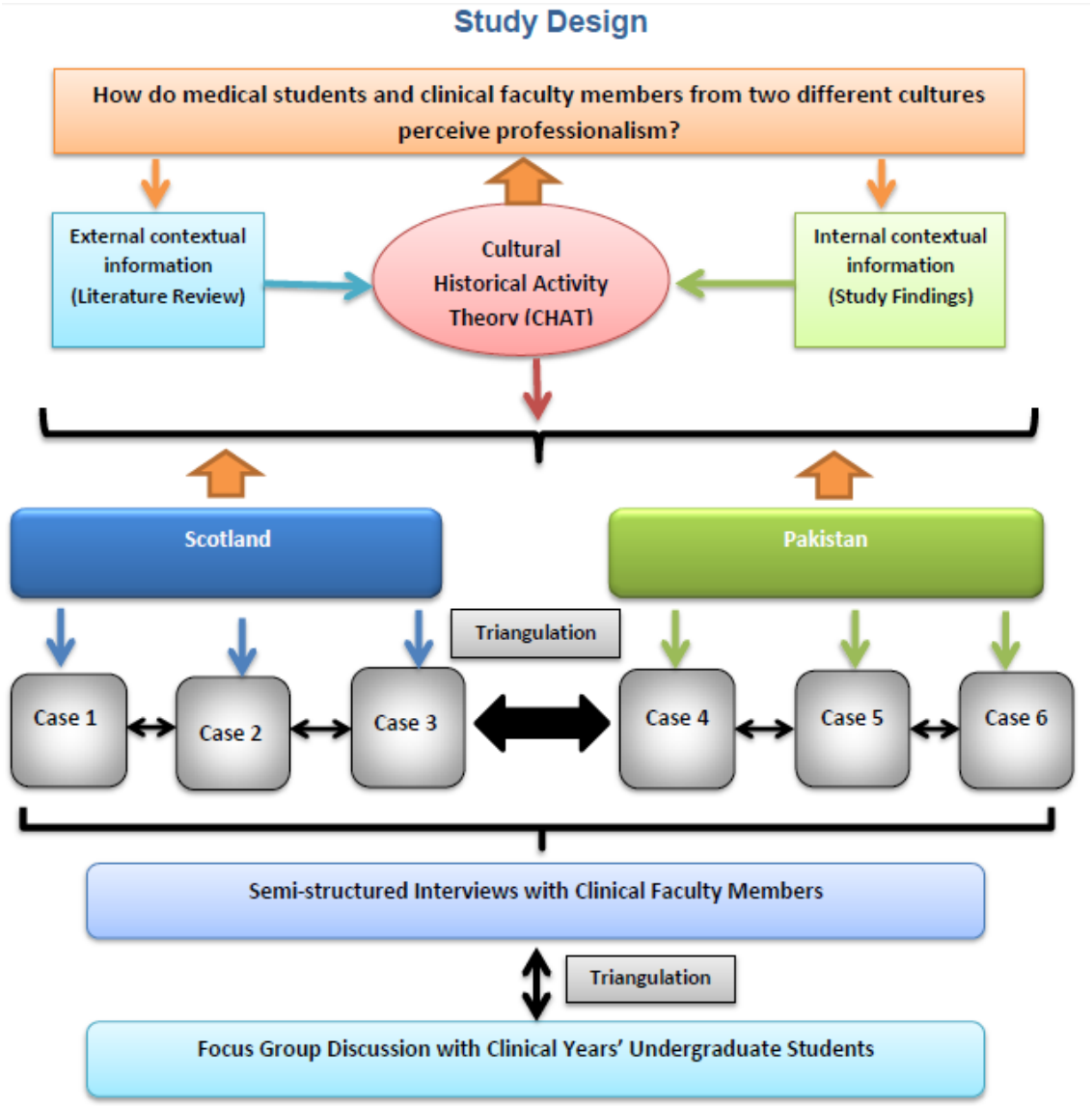


Figure 15: A model for the study design.
The thin arrows pointing downwards show the progression of study. The three thick arrows pointing upwards show the progression of study towards the end point. The double arrows and horizontal arrows show different levels of triangulation.

Chapter 5

Results

Chapter 5: Results

Key points

- The results are broadly divided into three sections. The first section reports observations and perceptions of study respondents from individual medical schools. The second section provides a comparison of medical schools within a country, and the third section is a comparison of cases across Pakistan and Scotland.
- The themes identified are the role of the healthcare system, curriculum, teaching and assessment, roles, approach towards patients, working in teams, self-regulation, the role in society and families, and dealing with conflict situations in the workplace.
- The attributes of professionalism vary depending on the different roles of a doctor, such as shifting from the role of facilitator to the role of assessor.
- The approach towards patients is context-centred, which means it can be patient-centred, doctor-centred, or task-centred, depending on factors such as, patient-overload and time constraints.
- Self-regulation is mostly informal and there is a need for strong external regulation.
- There is no formal training to manage conflict situations.

Introduction

As noted, the study engaged participants from six medical schools, three from Scotland and three from Pakistan. Each medical school, along with its affiliated teaching hospitals, was considered as one case. The affiliated teaching hospitals were taken as part of the medical school in order to include clinical faculty members because most of these work in hospitals. The clinical faculty members (5-9 clinicians) who teach in the medical schools were interviewed from each medical school, and one focus group (7-10 students) was arranged with students from the clinical years of each medical school.

Table 13 shows the distribution of maximum variation purposive sample across two countries.

Table 13: The distribution of sample across Scotland and Pakistan.

	Scotland			Pakistan			Total sample size
	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	
No. of faculty members	5	5	5	9	6	6	**36**
No. of students	7	7	9	8	10	10	**51**
Total sample size	**12**	**12**	**14**	**17**	**16**	**16**	**87**

The results are arranged in accordance with the research questions. The four research questions were:

- How do cultural differences affect the professionalism of doctors?
- How do medical students from different cultures perceive professionalism?
- What are the cultural similarities and differences in understanding professionalism, within a country?
- What are the cultural similarities and differences in understanding professionalism across cultures?

According to these four research questions, the results have been organized in three sections. In the first section, the findings from each case will be reported individually. The summary of results will be presented in the form of figures which will show the themes and sub-themes, followed by explanations in the form of written text. In the second section of the results, the intention is to answer the third question of this study, to compare medical schools within the country. This section will be divided into two parts, first part for Scotland (Case 1, 2, and 3 combined), and the second part to show the cultural differences within Pakistan (Case 4, 5, 6). The results will be shown in the form of tables, followed by their explanations. The third section will show the combined results of multiple case studies from both countries. The purpose of this section of results is to answer the fourth question of this study. The results in this section follow the same format of

tables and text presentations, as in the sections before. A list of criteria for professionalism is given in the Table 34 in an appendix section (Appendix 3).

Section 1: Single case study results

This section reports about perceptions of study respondents from all the six cases. The findings from each case are sub-divided into:

- Perceptions and observations of professionalism reported by faculty members.
- Perceptions and observations of professionalism reported by student.
- The similarities and differences in perceptions of professionalism, among them.

The summary of results is displayed in the form of figures, followed by written text.

Case 1

The first case was a medical school from Scotland. Five clinical faculty members were interviewed, and a focus group session was arranged with 7 students from Year 4. This medical school is one of the largest medical schools in Scotland and the students work in over twenty hospitals. The faculty members were senior clinicians from General Practice, Medicine, and ENT. The themes and sub-themes for both groups are shown in Figure 16 & 17.

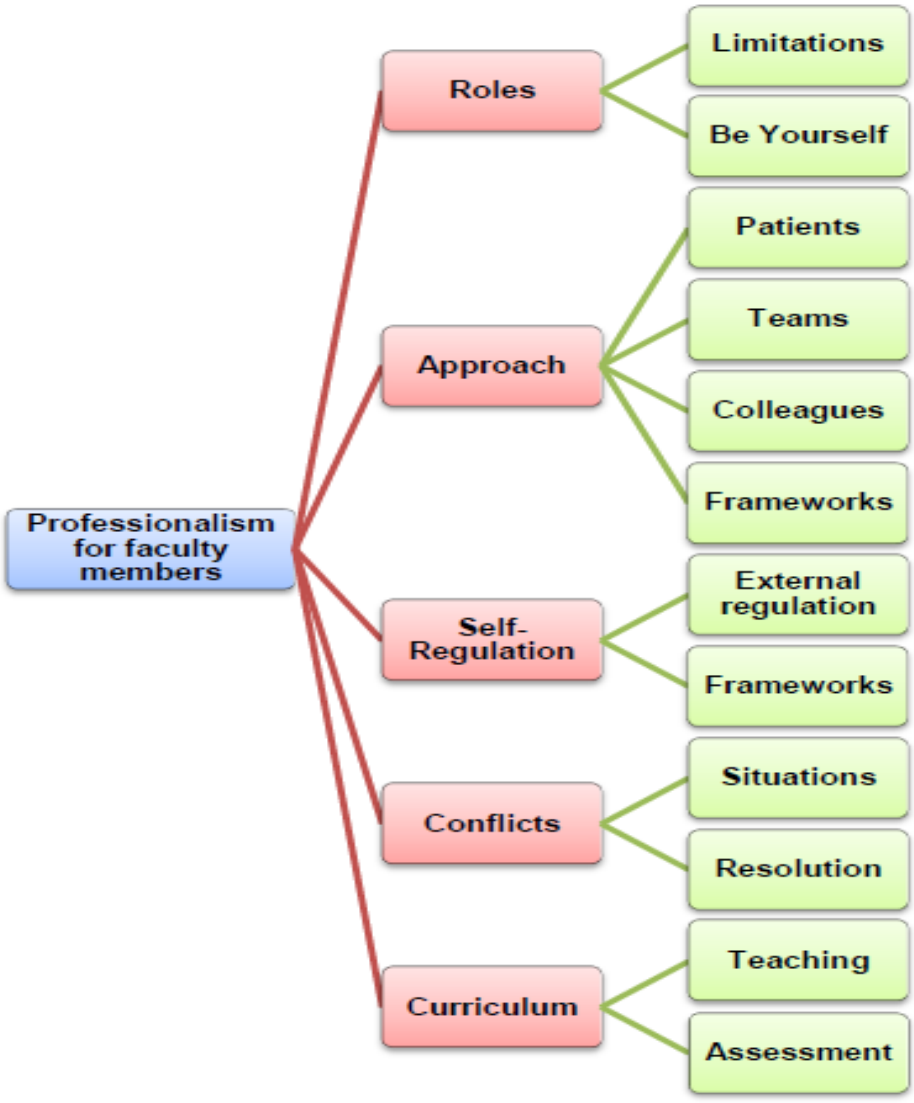


Figure 16: A framework summarising themes and sub-themes for professionalism. (Case 1, faculty members)

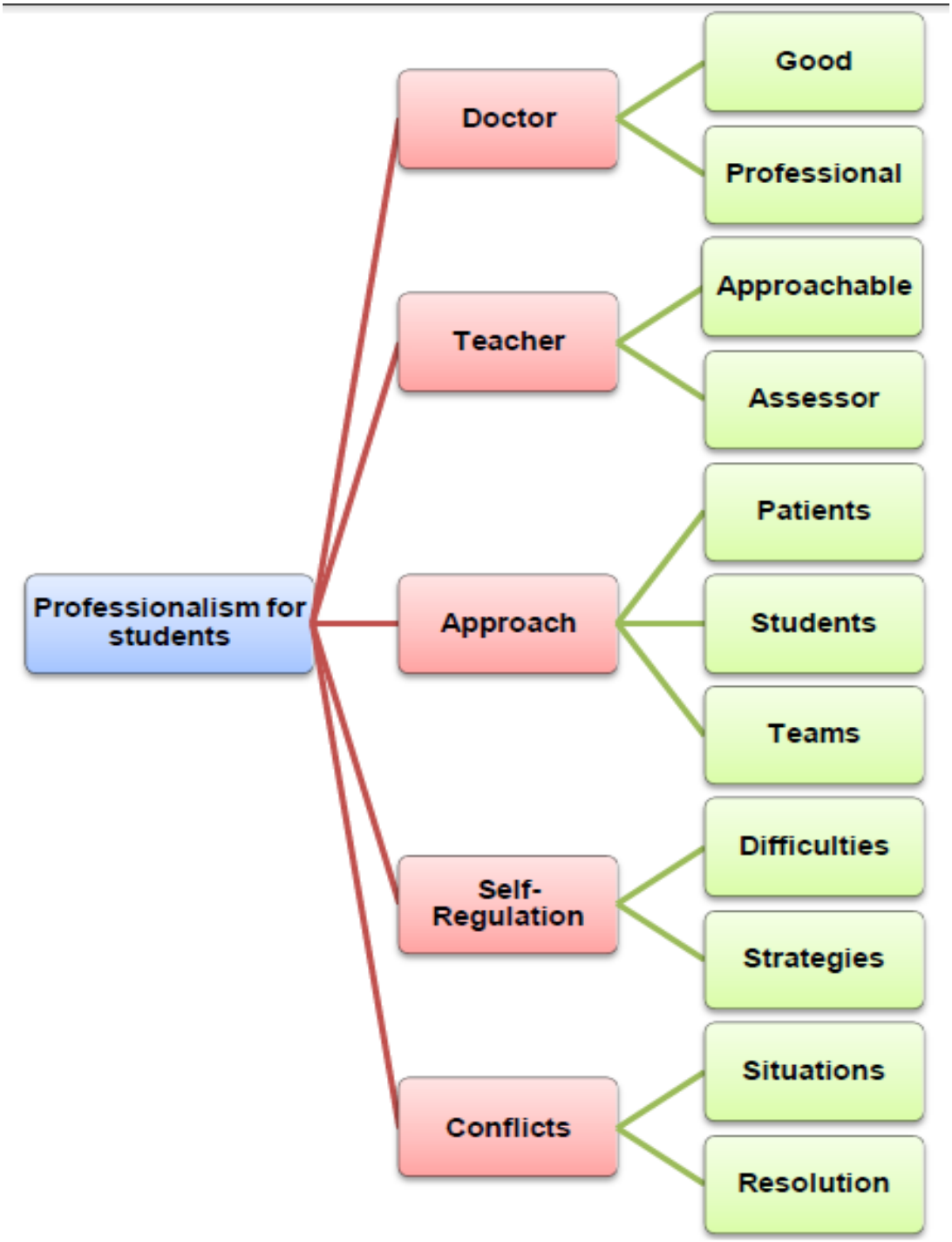


Figure 17: A framework summarising themes and sub-themes for professionalism. (Case 1, medical students)

Similarities in perceptions of students and faculty members

The overall approach towards patients, colleagues and team working was mostly found satisfactory. However, still there is a need for improvement in some areas, such as communication skills and conflict resolution. The study respondents from Case 1 reported that, there were few doctors who had an attitude problem, while dealing with colleagues and students but generally, it did not have a negative effect on the care of the patients. The teams working in small setups such as, in GP care or small hospitals are much better than in the large hospitals. Within the large hospitals, professionalism in team working also depends on the type of workplace, for example, Stroke and A&E teams were perceived to be working well as a team. The students reported that the regulatory body is demanding too much from doctors and medical students, and do not have a realistic approach towards regulation. Doctors and medical students commonly face conflict situations, and all study participants agreed that more training is required in conflict resolution. Two representative statements for approach towards patients are given below to show similarities in perception of faculty members and students.

> "Treat people the way you would expect yourself to be treated. Work in partnership with them." (JM FP2 C1)

> "Approach empathetically. Ideally, doctors should be non-judgemental. They should listen carefully, provide privacy to patients, offer treatment options to patients, and should communicate respectfully according to context." (FGD Students C1)

Differences in perceptions of students and faculty members

The data analysis showed that the doctors had a more professional approach, whereas the students had a more humanistic approach. However, the difference is not that much as the students also had an exposure of hospitals for two years, and were able to understand the restrictions imposed by the system. The only difference was because of the experience, and maturity. The doctors said that 'values define professionalism' whereas the students considered 'appearance' as an important factor for professionalism. The doctors thought that the team working was more professional but students, as observers, viewed it differently. The students could

appreciate the power dynamics working within the teams and how they were influencing the teams. However, the doctors did not mention about power dynamics within teams, probably because they themselves were all at senior level.

The focus of discussion for faculty members was on patients and the regulator. However, students' focus was on teacher doctors and patients. The reason here again could be the power dynamics, as the focus was on those who have more authority due to their seniority. In the case of doctors, they mostly deal with patients and are regulated by the GMC through appraisal and revalidation, and hence are controlled by them. The students, however, focused more on their teacher doctors, and shared all those observations which do not form part of the formal curriculum. This suggests the importance of the informal curriculum, and role modelling, in the teaching and development of professionalism. Examples of representative statements for 'conflict situations' are given below to show the differences in perception of faculty members and students.

> "You have to challenge, collect evidence, be upfront, be honest, face up to it. It's not pleasant." (JG FP3 C1)

> "One clinician challenging clinical judgement of another for patient safety is professional. However, other getting offended and retaliating is not professional. It means accepting mistakes or lapse in knowledge is professional but doctors are afraid because of extreme criticism. In this way, blame game can be dangerous and can deteriorate professionalism." (FGD Students C1)

Case 2

The second case was a medical school from Scotland. Five clinical faculty members were interviewed, and a focus group session was arranged with 7 students from Year 4. The themes and sub-themes for both groups are shown in Figures 18 & 19. The first Figure shows the themes and sub-themes for the faculty members, and the second one for the students.

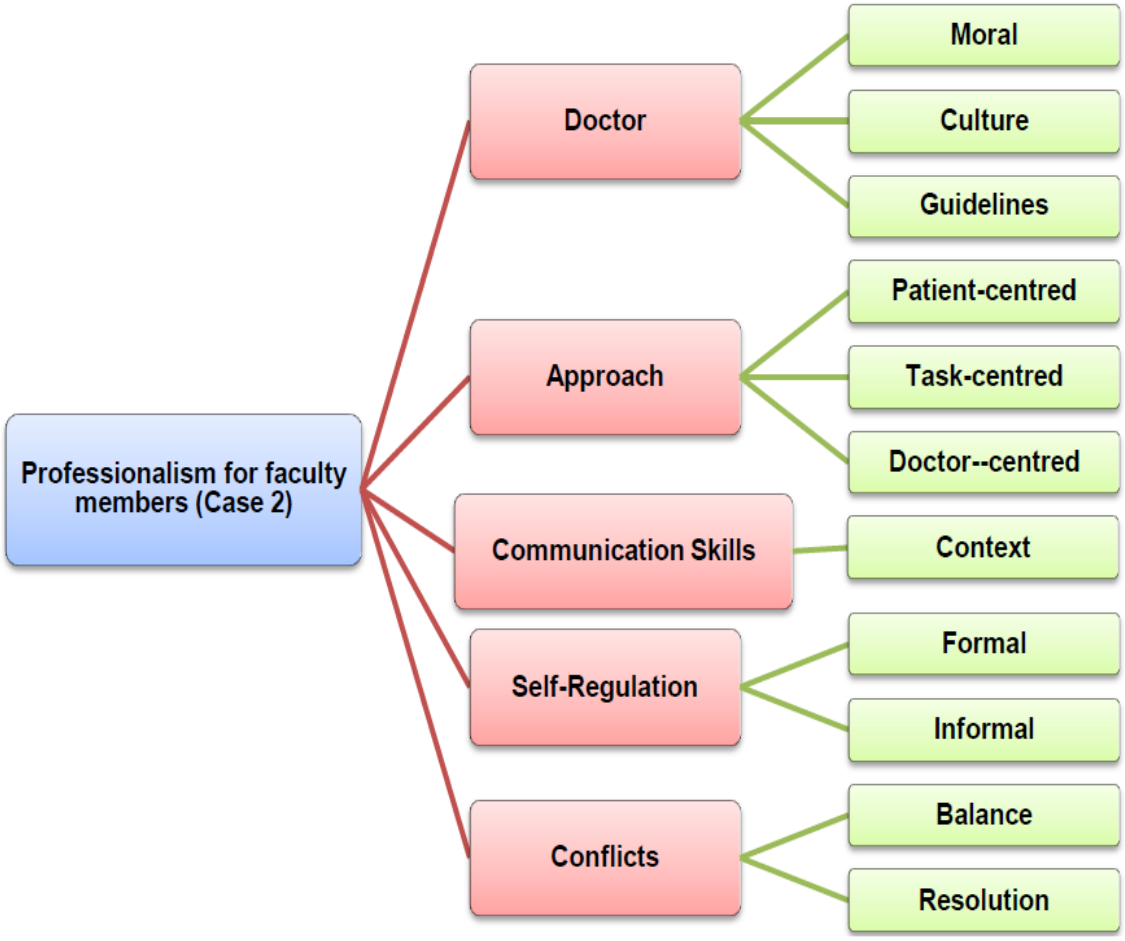


Figure 18: A framework summarising themes and sub-themes for professionalism. (Case 2, faculty members)

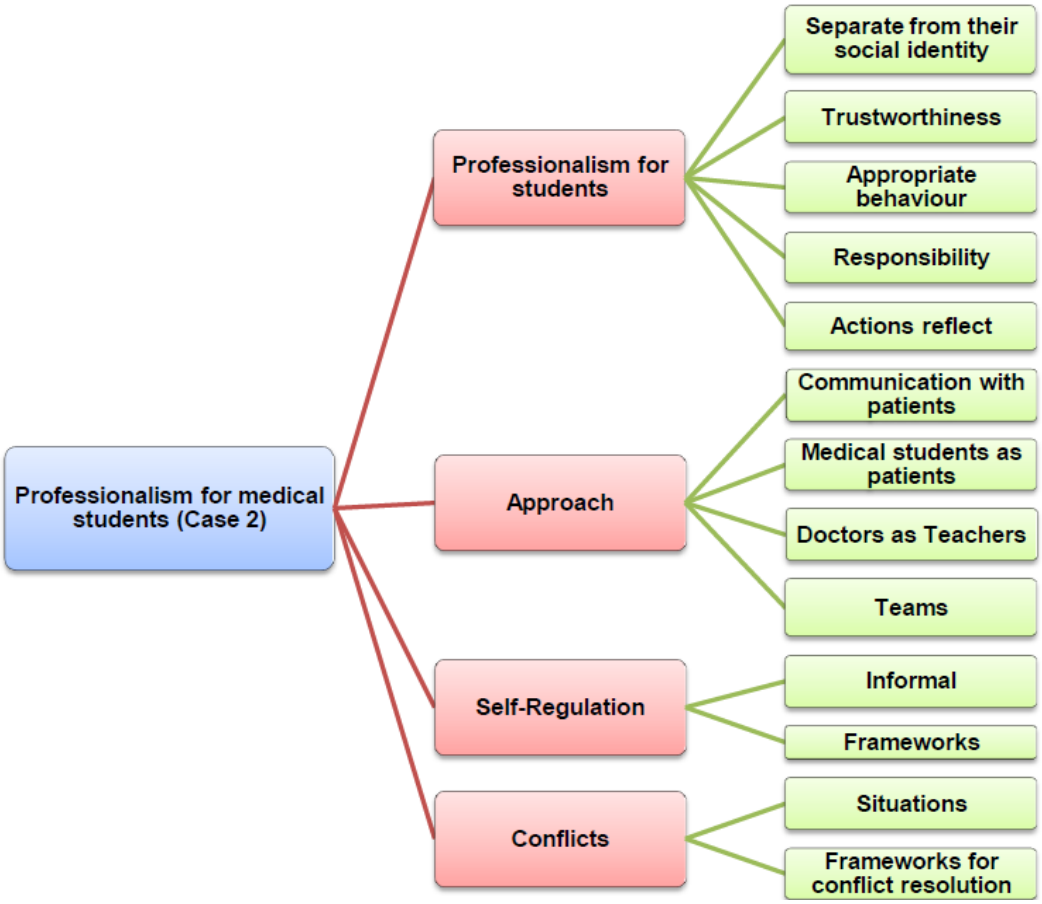


Figure 19: A framework summarising themes and sub-themes for professionalism. (Case 2, medical students)

Similarities in perceptions of faculty members and students

Doctors have different approaches towards patients, especially in communication skills. The study respondents agreed that professionalism is reflected in the behaviour of doctors, and it can show how responsible they are. The team working is usually professional, however sometimes one can have bad experience, either because of the personal or system issues. The faculty members had reservations on the 'revalidation' process which the GMC is planning to introduce. They were concerned that it will be the same as 'appraisal' exercise and no one will fail.

It was reported that society still respects medical community more than many other professionals, and doctors are highly trusted by society. The respondents stated that the doctors have become busy because of the overloaded healthcare system which is leading to many internal and external limitations, and may lead to conflict situations. The students and doctors are aware of the conflict situations and know

the means to resolve them. Some grey areas were mentioned, where medicine and law are not in congruence with each other, hence leading to dilemmas in clinical practices. Examples of representative statements for ‘informal self-regulation’ are given below to show the similarities in perception of faculty members and students.

> “On a day to day basis, I try to look for gaps in my knowledge, that's where I rely on experience and past recognition. I only practice one day a week, I recognise that, I am not as good as I used to be, so I have organised a system of decision support. I meet with my mentor every week when I am in practice. In medical school, we have seminars and meetings. It's about learning from each other. So, I think, it’s a good way on a day to day basis of self-regulating. Moreover, I adhere to more 'formal' systems for self-regulation, like 'appraisal' and 'performance review'.” (JK FP1 C2)

> “At the end of the day, you think of all the things you have done. You think, 'right, next time, I need to explain that better, do that more’. Your self-regulation and professionalism increases as you get more experience, it just kind of, builds up.” (FGD Students C2)

Differences in perceptions of faculty members and students

The students mentioned that generally the difference in communication skills is sometimes related to the generational difference. Some senior consultants follow the paternalistic model whereas the junior consultants follow the patient-centred model. The doctors further elaborated that the clinicians at times will either use a patient-centred, or a task-centred, or a doctor-centred approach, so as to make a best management plan, according to the available resources, and time. This was called a system-centred approach which encompasses all three approaches. The faculty were more aware of the self-regulation procedure than the students. The reason was their formal assessment through ‘appraisal’ process.

The students separated professionalism from personal life but the analysis of the transcripts of doctors’ interviews showed that some of them think that professionalism encompasses their personal as well as professional life. Examples of representative statements for ‘approach towards patient’ are given below to show the differences in perception of faculty members and students.

> “The central idea that most people have about patient's best interest are hard, that is, it doesn't always come across like that. I think from patient's point of view, often, it comes across as though, the doctor is really being doctor-centred, very focused on what their job is, and sometimes doesn't deal with the issues and important things, that patient necessarily wanted to bring into action.” (RJ FP4 C2)

> “Every doctor is busy but some of them can make you feel like that you are the centre of their attention, you mean so much to them even if, they have just 5 minutes with you.” (FGD Students C2)

Case 3

The third case was a medical school from the northern part of Scotland. Five clinical faculty members were interviewed and a focus group session was arranged with 9 students from Year 3. The themes and sub-themes for both groups are shown in Figures 20 & 21. The first Figure shows the themes and sub-themes for the faculty members, and the second one for the students.

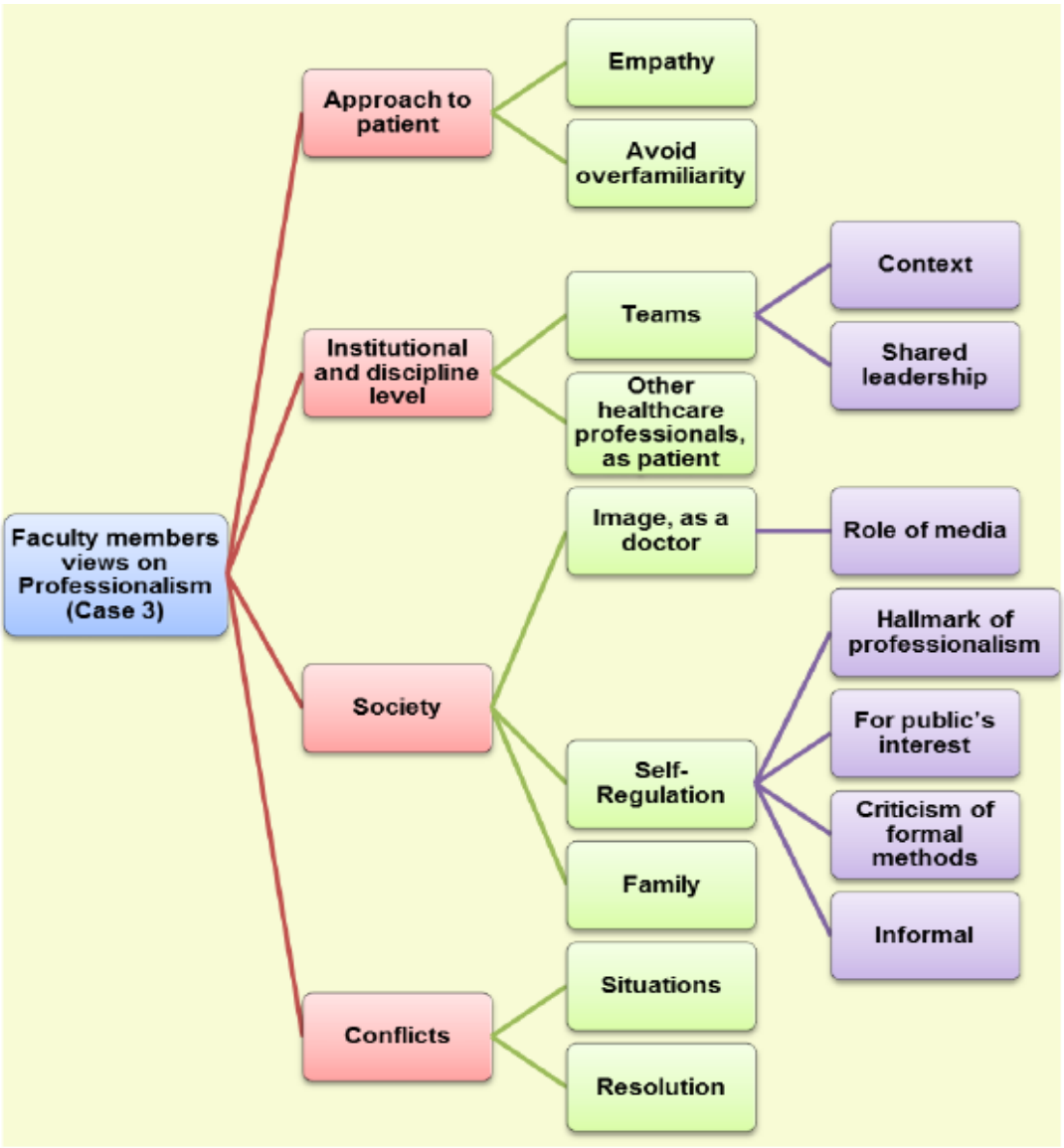


Figure 20: A summary of themes, sub-themes, and categories for professionalism. (Case 3, Faculty members)

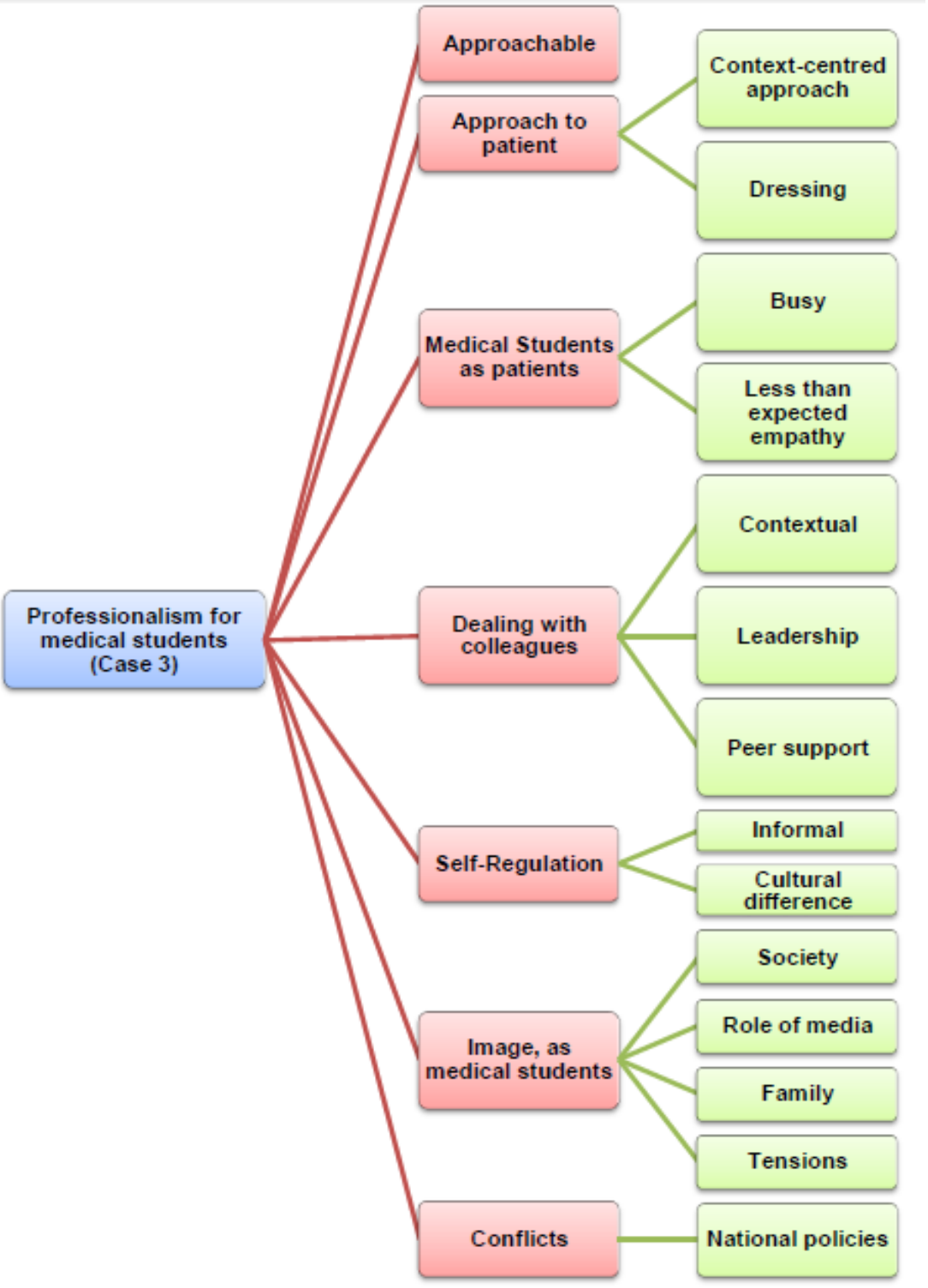


Figure 21: A framework summarising themes and sub-themes for professionalism. (Case 3, Medical Students)

Similarities in perceptions of faculty members and students

Both the groups agreed on the context specific nature of medical professionalism and agreed that professionalism is not absolute, but relative, and adjusted according to the situation. The study respondents mentioned dress as an important indicator to appear professional. The meaning in this context was an appearance which is socially acceptable to the majority of society. Examples of representative statements for 'appropriate dressing' are given below to show the similarities in perception of faculty members and students.

> "There is a professional look. I wouldn't see my patients in jeans. I see patients every day, so how would I dress; I wouldn't want to be overly familiar or informal. I want to keep up, a slightly formal side of a relationship." (SR FP2 C3)

> "The doctors should be apparently tidy because they are perceived to represent the medical profession." (FGD Students C3)

The study respondents said that they make efforts to maintain the image of a doctor in society, and may face some difficulties to keep up this image in the changing society. They also highlighted few issues with the role of media. They said that doctors are generally law abiding but there are few laws at national level, due to which doctors, on theoretical occasions, may feel conflict between practising medicine and the law. It was also mentioned that some laws were more relevant to leading conflicts in some specific specialities, such as a GP treating a drug addict, while in comparison; an interventional radiologist did not mention it as a conflict, because of his different job nature. Examples of representative statements for 'image of doctor in society' are given below to show the similarities in perception of faculty members and students.

> "Society on personal level regards doctors as people who are generally speaking decent people and want to help them. There is a counterview that doctors are over-paid, money grabbing, self-serving people who are occasionally incompetent and occasionally bungling. There is quite a good literature on discourse analysis, how doctors are portrayed, that's a very fascinating act in terms of how dodgy British doctors are portrayed and how dodgy foreign doctors are portrayed, in terms of the language that's used in newspapers. But, I think, generally speaking, doctors are regarded as a force for good and if not a pillar of society, more positive than negative aspect of society." (SR FP2 C3)

> "It's always known that the society has a judgement upon doctors so when you take a choice to go for a career in medicine, you are taking all that on board. So you can't use an argument of 'I will do what I do at my own time'. You chose the routine that comes with the career. You have to be willing to adopt yourself to that part of the career which is society's impression of you. Society is always going to have an impression that's never going to change so you have to adopt yourself to what society see you to be." (FGD Students C3)

Differences in perceptions of faculty members and students

The students stated that a doctor needs to be approachable to the patients, but the doctors did not mention it as an attribute for professionalism. This difference indicates a cultural variation, as the respondent clinicians were native UK residents, while most of the students in the FGD were from different Asian backgrounds. In Asian countries, where the healthcare system is not very strong, a doctor can be approached at mid-night by a neighbour. In the UK, this is not a common practice because of the way the healthcare system is organized.

Examples of representative statements for 'approach towards patient' are given below to show the differences in perception of faculty members and students.

> "With knowledge, tactfulness, and deference if the context is appropriate because it all depends. There will be some situations, for example, if there is a polytrauma case and you need to get the patient to theatre but theatre nurse doesn't want to finish her tea break, you might have to be very assertive and potentially even aggressive but that's the context of what you can do to improve the care of your patient. So, it's about being sensitive to the situation in which you find yourself, sensitive to the culture in which you find yourself, sensitive to the resource availability or constraints that you have as well, and also being mindful of any congruence or lack of congruence between your own position and that of the patient as well." (AD FP3 C3)

> "An approachable individual so patients are comfortable with him, and feeling free in communicating with him." (FGD Students C3)

Case 4

The fourth case was a public sector medical school from Khyber Pakhtunkhwa (KP) province, Pakistan. Nine clinical faculty members were interviewed, and a focus group session was arranged with 8 students from Year 4. The themes and sub-themes for both faculty members and students are shown in Figures 22 & 23.

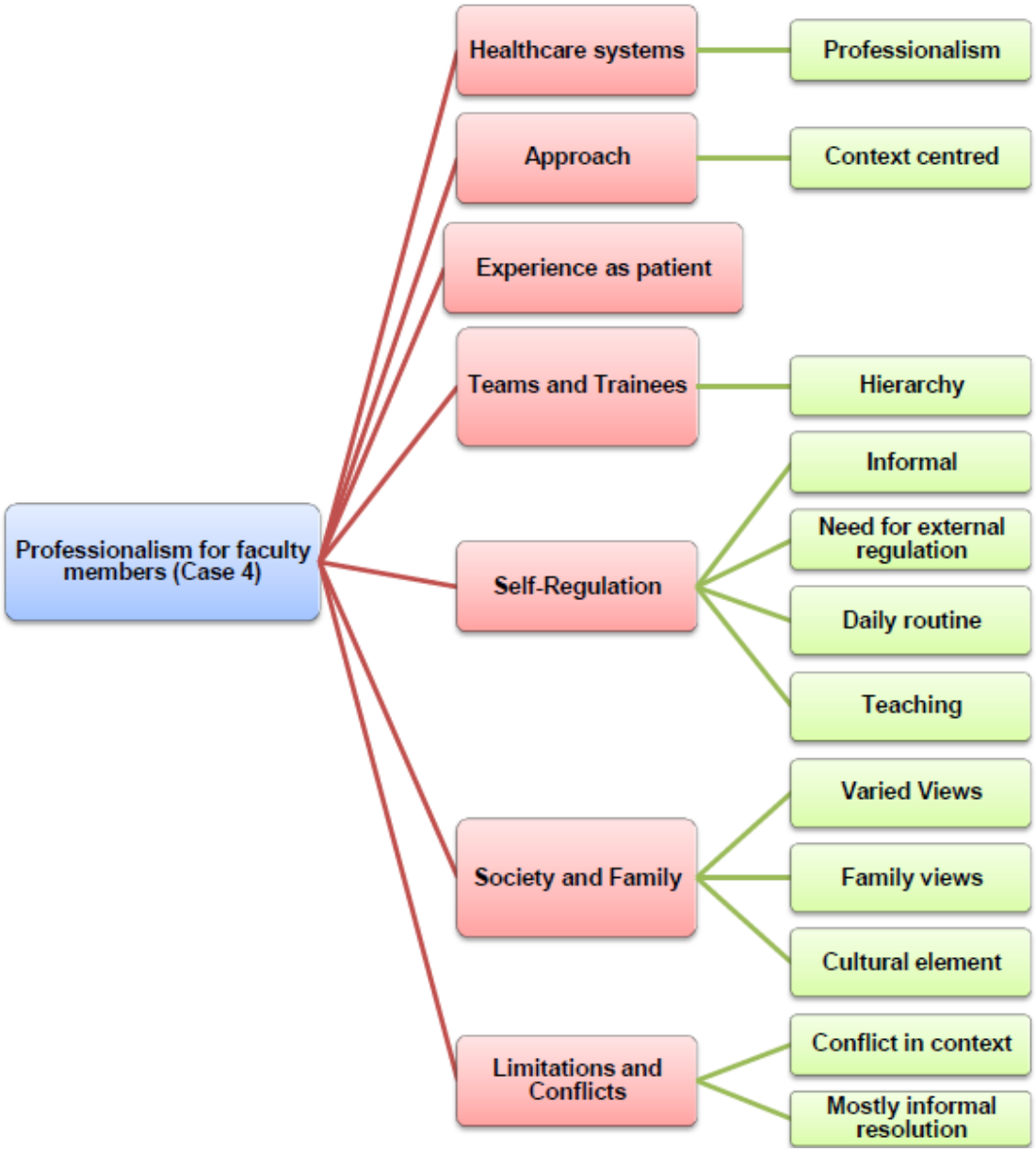


Figure 22: A summary of themes and sub-themes for professionalism. (Case 4, faculty members)

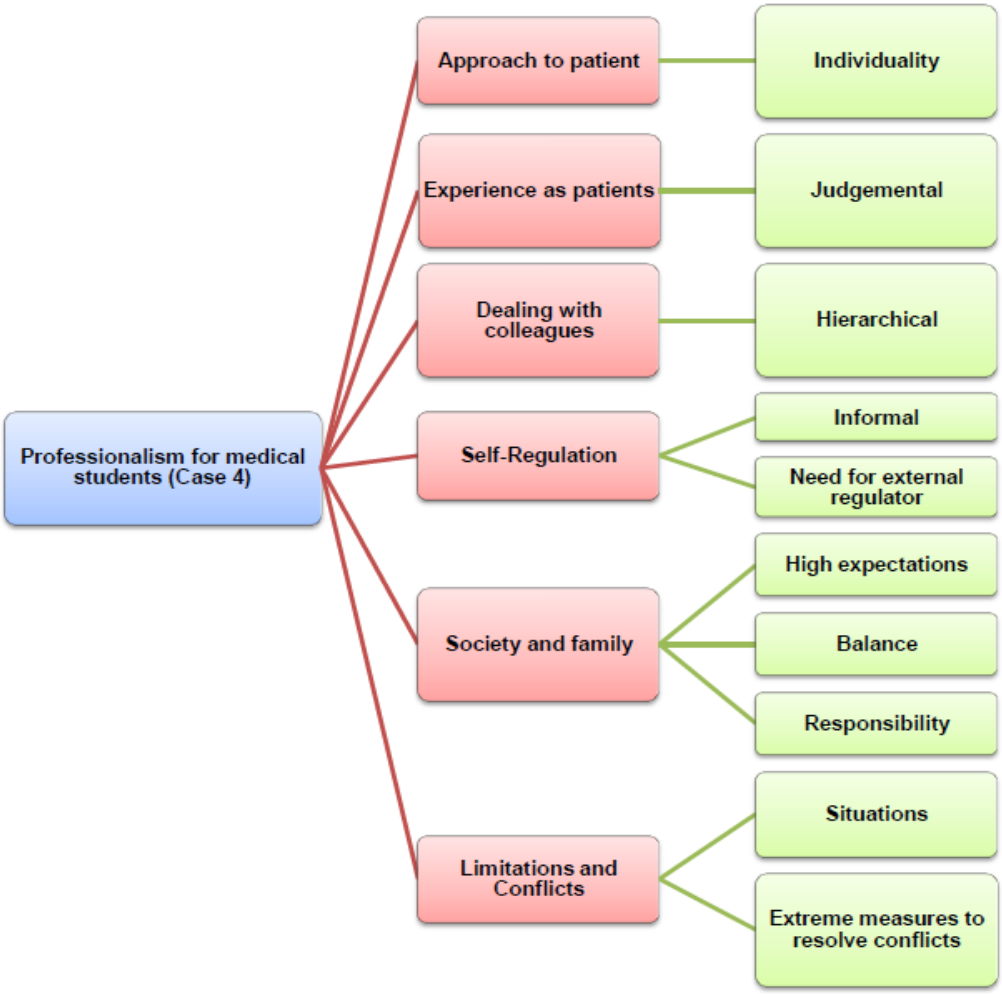


Figure 23: A summary of themes and sub-themes for professionalism. (Case 4, medical students)

Similarities in perceptions of faculty members and students

The study respondents from Case 4 mentioned, 'knowing limitations' and 'empathy' as professional attributes. They considered ethics as fundamental part of professionalism. They said that there is no training in professionalism, due to which they are unaware of most of the criteria for professionalism. Moreover, the non-technical skills are not considered as a priority. The approach towards patients is doctor-centred. Strong hierarchies are followed in teams, where the consultant is the team leader. Still, a positional leadership model is followed. The attitude of senior consultants is fine with colleagues but they do not value their trainees. Same is the case with other healthcare professionals. The team working is weak because of the lack of training, but still, the surgical teams work better than the medical teams. Self-regulation is informal, usually seeking guidance through religion. It

needs to be imposed by an external regulator to follow it robustly, and to provide evidence for self-regulation. The families view doctors and medical students with very high regards. Examples of representative statements for 'informal self-regulation' are given below to show the similarities in perception of faculty members and students.

> "If we take self-regulation in the context of continuous professional development so we are lacking. The reason is that, we don't have avenues or we don't have opportunities to self-regulate or to improve our professional development. If provided with opportunities, we will definitely improve. I will give you the example of our university. We have started 'Health Professions Educations Programme'. There are number of people applying for the Masters programme in our University, or in Karachi (city in Pakistan). These are just two avenues. If we raise avenues, then we have the capabilities to do it. All we require is to have the right kind of avenues to improve our professionalism." (SMN FP8 C4)

> "It can be done both on the personal and the inter-personal level. On personal level, what you are, what you think is right, you should do that. Like regulate yourself before going to sleep, you should think, what was wrong, what should I do to improve it. This is the personal level. And then comes the inter-personal level, you should have good company and you should have good seniors to guide you." (FGD Students C4)

Differences in perceptions of faculty members and students

The doctors mentioned varied views of society from good to bad, but the students felt that they are highly regarded by the society. The faculty mentioned teaching as one of the methods for self-regulation and to stay up-to-date, but the students did not mention it, as they are not involved in the formal peer teaching activities. Various conflict situations were mentioned by both students and doctors. The doctors said that they usually resolve conflicts informally, by talking to each other or by involving a neutral third party. However, the students said that they have to take extreme measure such as a call for strike, to make administration hear their voice and that is the only way when they are given any importance. The students said that the doctors are judgemental, but the faculty members did not mention about themselves being judgemental. Examples of representative statements for 'conflict resolution' are given below to show the differences in perception of faculty members and students.

> "There is no established skeleton or framework but we try to resolve the conflict issues through dialogue. Sometimes a third person may be involved to resolve the issue between two opposing parties however, dialogue is the major medium." (IK FP3 C4)

> "Sometimes, an appeal doesn't work on administration, and the only option left is to 'strike'. And without this extreme measure, nothing happens. No one takes issues seriously until we call for a strike." (FGD Students C4)

Case 5

The fifth case was a private sector medical school from Khyber Pakhtunkhwa (KP) province, Pakistan. This medical school has strong Islamic religious values, and the main form of teaching professionalism is through informal curriculum. The medical school has introduced its own book, based on Islamic values for a professional doctor (44). This book was investigated by a group of Islamic and Ethics scholars, and finally edited by clinicians for relevance and an English expert for translation and explanation of the different Islamic quotes, which were in Arabic, not commonly understood in Pakistan. The quotes from the book were matched with evidence from the literature on professionalism and ethics.

Six clinical faculty members were interviewed and a focus group session was arranged with 10 students from Year 4. The themes and sub-themes for both groups are shown in Figures 24 & 25.

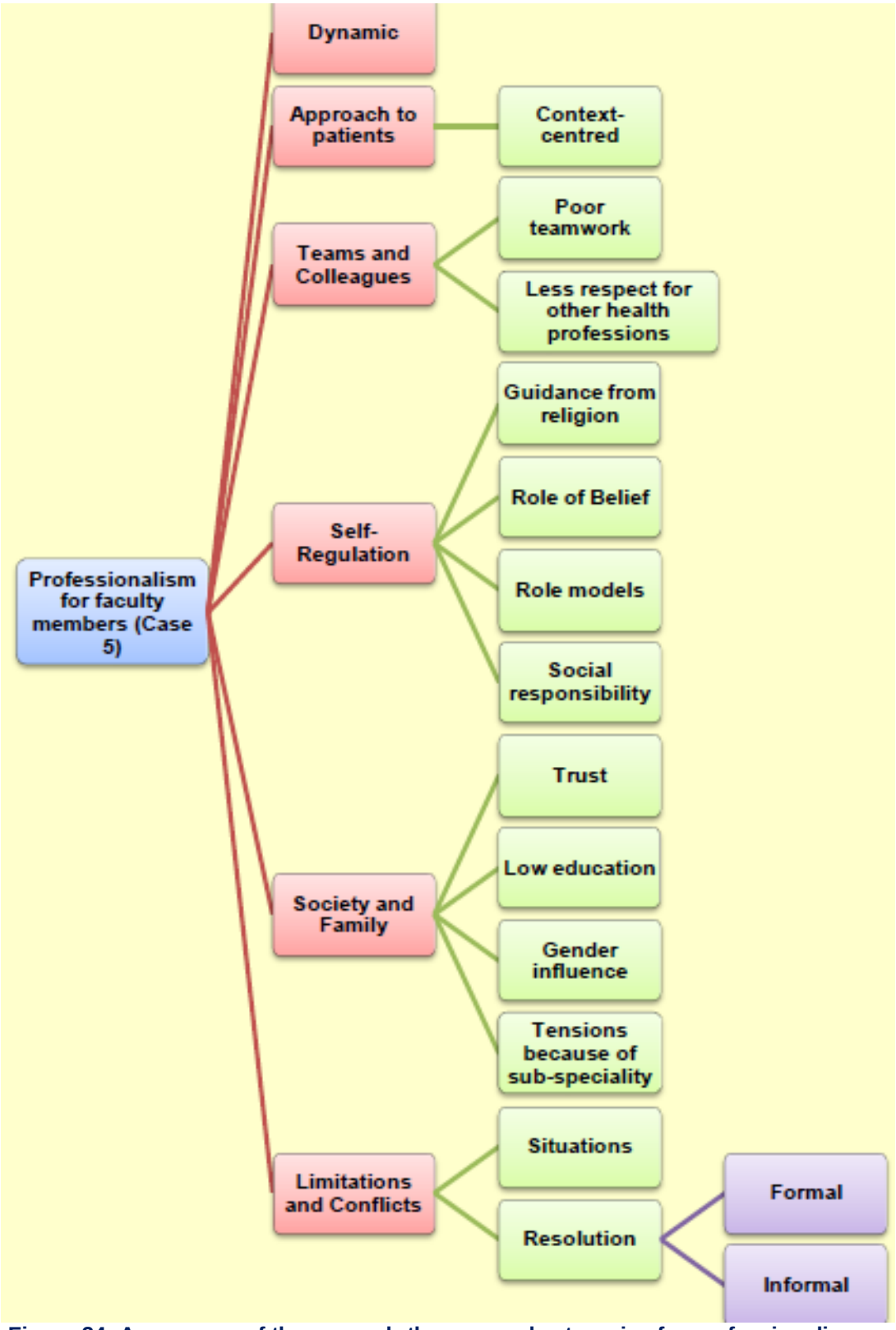


Figure 24: A summary of themes, sub-themes, and categories for professionalism. (Case 5, Faculty members)

Figure 25: A summary of themes and sub-themes for professionalism. (Case 5, medical students)

Similarities in perceptions of faculty members and students

The study respondents reported that professionalism is dynamic. It includes multiple domains, dimensions, and different approaches to practices. The approach towards patients is variable and mostly depends on the personality of the doctor. Self-regulation is informal, usually seeking guidance through religion. It needs to be imposed by an external regulator to standardize the practices across the country. It was mentioned that society has negative views about doctors. The main reason is the weak healthcare system, due to which doctors are unable to provide a satisfactory care to patients. However, society has high expectations from doctors, the reason for which is low education of the community, and they expect that a doctor or a medical student may know everything about the disease processes.

Examples of representative statements for ‘dynamic nature of professionalism’ are given below to show similarities in perception of faculty members and students.

> “The three arms of medical education are knowledge, skills and attitude, and putting the first two into the third one is basically professionalism. It is not only the knowledge and skills of the textbooks of medicine or other related subject curricula but also the overall comprehension of the knowledge of the society, their culture, their values, and then applying that knowledge in the sociocultural context. A doctor should behave in that particular way to apply that knowledge and skills, and that is professionalism. It includes his competence, his knowledge of the subject, and his attitude toward patients, colleagues, and students.” (NUH FP6 C5)

> “With knowledge and skills, he should adopt ethics and Islamic values for being a good doctor. As a Muslim, virtuous values are a basic thing in our society. If we follow religious values along with professionalism, it gives us everything that we can learn, and we can apply.” (FGD Students C5)

> “A good doctor is based on his attitude. Medicine is not noble of all the professions but its requirements are also very strict and hard.” (FGD Students C5)

Differences in perceptions of faculty members and students

The students said that doctors have a social responsibility towards their patients in their private clinics, by providing them facilities other than consultation process, but the faculty did not mention any such responsibility. The students stressed on the ‘role of research’ to improve collaboration and team working but the faculty did not mention it. The students felt that the lack of motivation cannot be attributed to faculty only, but students are equally responsible for it. Various conflict situations were mentioned by both students and doctors. The doctors said that they usually resolve conflicts informally, by talking to each other or by involving a neutral third party. The students said that they need training in communication skills so as to properly resolve conflict situations. Examples of representative statements for ‘variation in social responsibility’ are given below to show differences in perception of faculty members and students.

> “A significant number in this society are self-regulating. I say so because I have the experience of many doctors who would see their patients in their private clinics free of cost, many surgeons who would operate without charging any money. ‘Why?’ Because of self-regulation, even when the law and PMDC allow them to charge. So, I think there is reasonable number of doctors who self-regulate.” (NUH FP6 C5)

> “I went to one of my Professors private OPD. His PA said that his timings are from 5 to 9 pm, but it was 8 pm and he was not there. Lot of patients were waiting for him. There was no light and he had no arrangement of a generator or UPS (Uninterrupted power source). If he is having a job in public sector and also owns a private clinic, he must be economically good enough to buy a generator or a UPS. So, in that hot weather, all the patients were sitting there.” (FGD Students C5)

Case 6

The sixth case was a private sector medical school from Rawalpindi city, Pakistan. This city is in the Punjab province, over 100 miles away from Peshawar. Professionalism is mainly experienced through the informal curriculum. Six clinical faculty members were interviewed and a focus group session was arranged with 10 students from Year 4 in the first week of March, 2013. The summary of the themes and sub-themes for both groups are shown in Figures 26 & 27. Some of the themes and sub-themes which came out from the data, such as 'professionalism as dynamic' are not repeated in this section so as to include some new themes. However, they will be present in the combined themes in the next two sections of results.

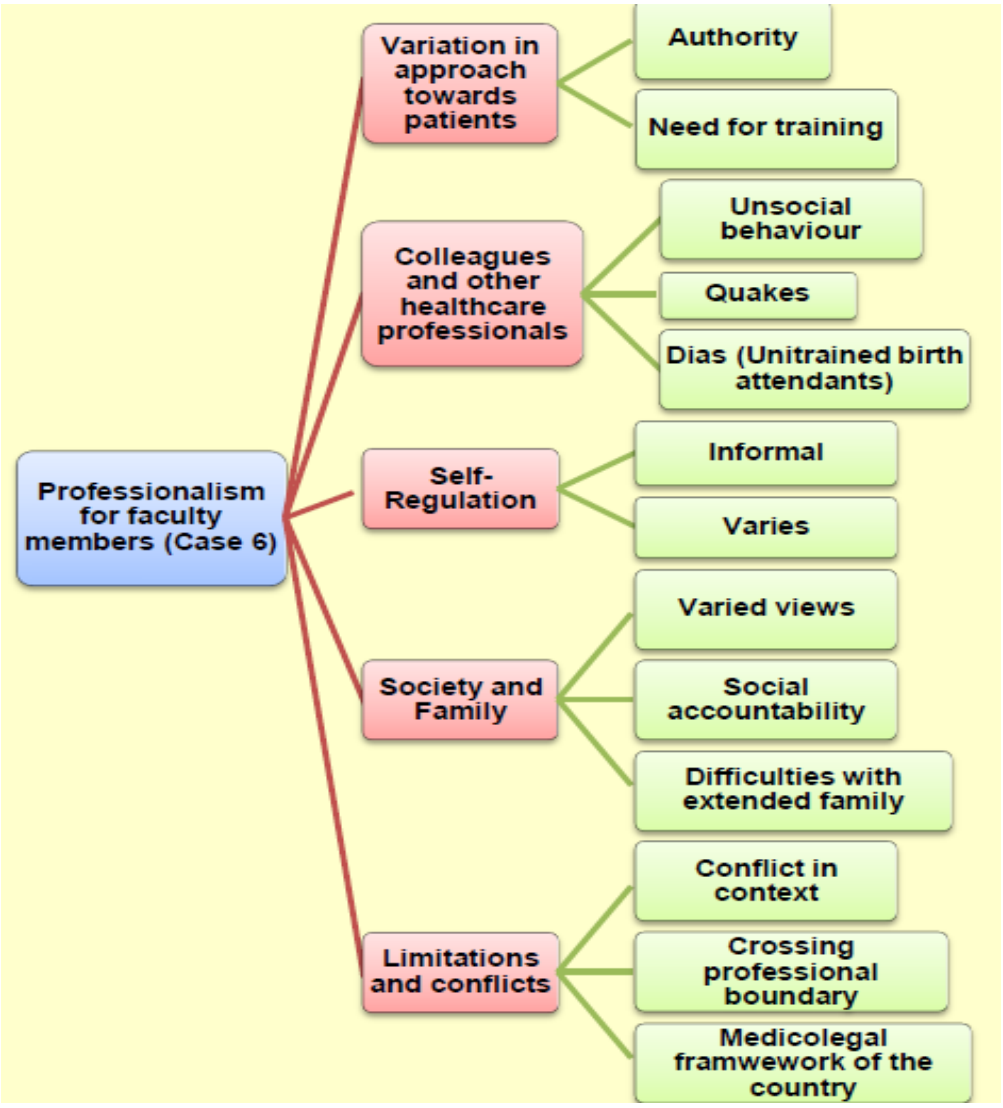


Figure 26: A summary of themes and sub-themes for professionalism. (Case 6, Faculty members)

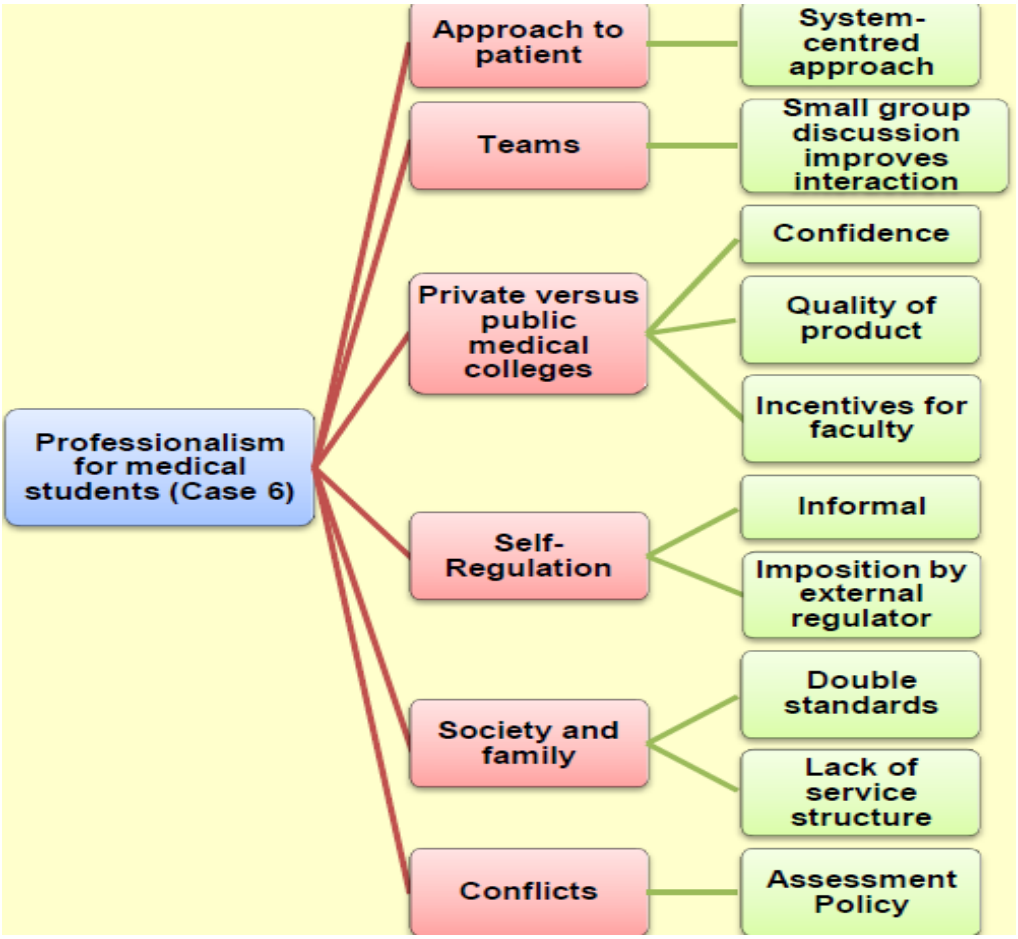


Figure 27: A summary of themes and sub-themes for professionalism. (Case 6, Medical Students)

Similarities in perceptions of faculty members and students

The study respondents reported the contextual nature of professionalism. They said that the approach towards patients is variable, mostly paternalistic. It is also influenced by many confounding factors, such as patient-overload, and training of doctors. The study respondents mentioned the role of a doctor as practitioner, researcher, and administrator. Team working is weak because of lack of training. Self-regulation is informal, usually seeking guidance through reflection and role modelling. It needs to be imposed by an external regulator because it cannot be collectively practiced by the doctors' community, on individual basis. Therefore, training in communication skills and teamwork is required for improvement in professionalism.

The lack of service structure was mentioned as one of the biggest weakness of the healthcare system, which is the cause of most of the doctor's problems. It has negatively affected their reputation because the junior doctors went on a nationwide strike for the establishment of service structure over the last two years. However, the government did not respond to their demands, and used force to bring them back to their duties. Meanwhile, the electronic and print media presented negative images of the doctors and mentioned them as self-centred, thus further worsening their image in society. The respondents also mentioned that society has double standards towards doctors. Their views and expectations differ. They view doctors as self-centred but expect very high from them. Examples of representative statements for 'patient overload' are given below to show similarities in perception of faculty members and students.

> "In our setup, lots of things form hurdles when doctors practice in hospitals. A practical example would be a doctor seeing 40-50 patients in an hour or two. Most of the time patients are not that literate that they would understand what the doctor is trying to say. The support that a doctor has is very poor." (RK FP1 C6)

> "In Pakistan, doctors are less and there is a heavy load of patients. The patients expect that they'll be listened, and will get proper time but the doctor has to see a lot of patients and he gets tired. He is so fed up by the end that he will try to finish it quickly." (FGD Students C6)

Differences in perceptions of faculty members and students

The faculty members mentioned 'use of authority' for patients care and safety but the student's focus was on the behaviour of doctors towards patients. One of the reasons for mentioning the term, 'authority' can be the hierarchical structure which is followed in this medical school, as some of the senior faculty members are retired armed forces doctors, and follow a hierarchical military culture. The students in their undergraduate course are being trained for working in teams through their teaching activities such as small group discussions. However, the faculty and trainee doctors did not have formal training in teamwork and they perceived team working to be weak. One of the faculty members also mentioned the positive role of 'social media websites', which he uses for staying up-to-date and for sharing his clinical queries. The students did not mention the use of social media for professional development.

The students mentioned the psychological stress of low confidence while studying in a private medical school because the general view in the society is that these students are buying degrees. This puts them under stress and there is no such formal support from the faculty to boost the morale of these students. It was realised that few of the faculty members also had the same societal views about their students, which might be one of the difficulties to launch such actions to boost the self-esteem of these students. The faculty members mentioned about the 'social accountability' but the students seemed unaware of such concept, may be because they have not been taught yet, or because of lack of professional experience. They might be doing some good practices, considering it as their 'social responsibility' but none of them mentioned the term. However, the students did share some stories, where they felt that the doctors, they observed, were short of their social responsibility. Thus, the students may not know the term but are aware of their responsibilities towards the society.

Examples of representative statements for 'range between external regulation and self-regulation' are given below to show differences in perception of faculty members and students.

> "External regulation is not very prevalent over here, and we cannot be completely regulated by external bodies. We need to self-regulate ourselves, and I think that a very strength we have is in our religion such as, principles of commitment to excellence, and accountability. These principles motivate us to regulate ourselves. Additionally, we should take feedback from our colleagues, students, and patients on our teaching practices. It will help us in self-regulation." (FM FP2 C6)

> "We can't work ourselves that much if we don't have an external regulator. We cannot properly self-regulate. We need a powerful external regulator to control us such as, PM&DC (Pakistan Medical & Dental Council)." (FGD Students C6)

Section 2: Comparison within the country

In this second section of the results, the intention is to answer the third question of this study:

- What are the cultural similarities and differences in understanding professionalism, within a country?

This section is divided into two parts, the first one is for Scotland (Case 1, 2, and 3), and the second part is to show the cultural differences within Pakistan (Case 4, 5, 6). In these results a comparison has been drawn between medical schools from different cities but within a country. These are shown in the form of commonalities and differences according to the contexts. The results are shown in the form of tables, followed by their explanations.

Multiple case study results from three Scottish medical schools

The total sample size from Scotland was of 38, which included interviews from 15 clinical faculty members, and three focus groups with 23 clinical years' students. The themes and sub-themes for faculty members and students from three Scottish medical schools were triangulated, and are shown in Table 14 & 15.

Table 14: A summary of faculty members' perceptions of professionalism, from three Scottish medical schools.

Themes	Sub-themes
Roles	• Morals • Guidelines • Culture • Limitations
Approach to patient	Context-centred, combination of: • Patient-centred (ideal) • Task-centred • Doctor-centred
Teams, colleagues and other healthcare professionals	• Context dependent • Shared leadership
Self-regulation	• Hallmark of professionalism • For public's interest • Criticism of formal methods • Informal
Image of a doctor	• Society • Role of media • Family
Conflicts	• Context • Conflict Resolution

Table 15: A summary of students' perceptions of professionalism from three Scottish medical schools.

Themes	Sub-themes
Roles	• Appropriate behaviours according to different roles
Approach to patient	• Context-centred • Empathy (less than expected) • Busy (doctors appear busy)
Teams, colleagues and peers	• Context • Leadership • Doctors as teachers • Peer support
Self-regulation	• Informal • Cultural differences
Image as medical student	• Society • Role of media • Family • Tensions
Conflicts	• Context • Resolution

Triangulation between faculty and students' views is done for a holistic picture to understand professionalism in Scotland. Table 16 shows the combined themes for perceptions of professionalism in Scotland.

Table 16: A combined summary of faculty and students' perceptions of professionalism from three Scottish medical schools.

Theme	Description	Brief Explanation
Professionalism	Dynamic	Multi-dimensional, with different levels, such as individual, inter-personal, institutional, and societal level.
Approach to patient	Context-specific approach	The approach towards patients varies in practice, depending on time constraints, roles, high versus low-pressure situations, and during transition periods. The context-specific approach is a compromise between patient-centred approach, balancing the resources, time constraints, and addressing the internal and external conflicts.
Dealings with colleagues, teams, and other healthcare professionals	Contextual	There is variation from good to bad behaviour, depending on many factors such as, time limitations, finances, generational difference, speciality area, team size, training, role of leader, power dynamics, professional courtesy, level of interaction, cultural differences, working conditions, hierarchy, personal conflicts and agendas, boundaries, and peer support.
Self-regulation	Mostly informal for students, and formal for faculty members, that is, imposed by an external regulator, such as GMC.	Self-regulation is considered as the hallmark of professionalism, and has been further explained as types of self-regulation, different levels, situations, new areas, and its limitations and disadvantages.
Society and Family	Varied views and expectations	Usually society and family has very high expectations of doctors and medical students, and they respect them. However, society as a whole is also changing rapidly and the views are influenced by the media, which may make a big news if there is a lapse in professionalism by doctors. Society demands responsibility and has now shifted to the accountability model, which has brought in the concept of external regulation, such as 'appraisal' and 'revalidation'.
Conflicts	Manage conflicts according to context	The faculty members and students shared different conflict situations related to personal, inter-personal, balance between personal and professional life, healthcare system, cultural variation, and law and legal situations. They also mentioned different ways through which, they usually resolve conflicts, which provides a general framework for conflict resolution.

Similarities in perceptions across cases

Students

The students from three Scottish medical schools reported different styles of communication skills. Some clinicians are more paternalistic, while others have a patient-centred approach in their communication skills. The empathy shown towards patients is less than expected. They said that few doctors are prejudiced and judgemental about the patients. The students always are made aware that they have to maintain the image of a doctor in society. They also mentioned that the family usually expects them to give advice on their health related issues, which they find difficult because they are not allowed. At times they do not know the exact pathogenesis of the disease which puts them in a difficult situation. Two representative statements for 'communication skills' are given below to show similarities in perception of students from three Scottish medical schools.

> "Approach empathetically. Ideally, doctors should be non-judgemental. They should listen carefully, provide privacy to patients, offer treatment options to patients, and should communicate respectfully according to context." (FGD Students Case 1)

> "I got personal experience with my sister who passed away 15 years ago before she was diagnosed with leukaemia. We took her to a doctor for stomach pain but he just casually checked her. After a month or two, we went to see another consultant. He said, 'she has got leukaemia'. So, you think if it was earlier diagnosed, may be things could have changed a bit. So you have to find who is really kind of empathetic and treat the patient as his own child." (FGD Students Case 3)

Faculty

The faculty across Scottish medical schools appreciated the shift from positional leadership towards a shared leadership in teams. They mentioned the importance of self-regulation and shared examples, how they practice it. Some of them showed concern that 'revalidation' may not properly serve its purpose. Three representative statements for 'self-regulation' are shared to show similarities in perception of faculty members from three Scottish medical schools.

> "By and large, we do have a culture of self-regulation. Appraisal and revalidation is a framework that allows us to improve professionally." (PC FP4 Case 1)

> "I take part in the appraisal process, and the clinical academic performance reviews so I have all my links up-to-date." (JK FP1 Case 2)

> "What's being proposed at the moment for 'revalidation', I don't think it's very convincing? It's too much like appraisal, and I don't think anyone is going to fail. I don't think we have really thought through, what you do if there are concerns, how do you support someone." (SR FP1 Case 3)

Overall similarities in perceptions of faculty members and students

Professionalism is dynamic: The study respondents from Scottish medical schools reported that professionalism is reflected in the behaviour of doctors, and it shows how responsible they are. They appreciated the importance of the context for a professional approach and agreed that professionalism is not absolute, but relative, adjusted according to the situation. An example of representative statement for 'professionalism' is given below.

> "I look at professionalism in a different way from other doctors because I've studied it. I believe that professionalism is political; it's very contextual. It's historically, socially and culturally based. So, there is no one answer to what professionalism is. It's actually a multi-dimensional construct which has different levels, i.e. individual professionalism, professionalism at the interface where you interact with your colleagues and patients, and the institutions that you work in, and then there is the wider professionalism which is professionalism to the medical society and how it interacts with the wider society. So, it's very difficult to define professionalism. In fact, there is no clear operational definition of professionalism that's been developed." (JG FP3 C1)

Approach towards patients: The ideal approach is patient-centred but due to other imposing factors, such as workplace condition, resource constraints, and time limitations; it is mostly context-specific approach, where the doctor is more sensitized to the context, including the patient. There are different ways of approaching patient in different medical disciplines, and in different roles. An example of representative statement for 'approach towards patient' is as follows:

> "A professional doctor should approach a patient using the principles of 'doing the right thing and do no harm'. You make sure that the patient is feeling comfortable with the process, and understand what's going on. You address all their concerns, and know how to deal with the problem and how much of that is dependent on them and how much of that is dependent on the doctor because it's not always dependent on the doctor. There are things that the patient can do to help themselves and that information will help you as well. (MF FP1 C1)

Dealing with colleagues, teams, and other healthcare professionals: The respondents stated that teamwork is usually professional. High-pressure situations may negatively affect teamwork in that some team members may become aggressive or

overburdened, which may lead to unprofessional behaviour. In small teams and setups, where the team members know each other, the working environment is more of a professional courtesy than in the large hospitals. Dealings with other healthcare professionals vary, depending on the situation, and approach of the individual doctor. Usually, it is good and although there is an establishment of power dynamics due to hierarchy, but the doctors appreciate and manage it accordingly. Examples of representative statements for teamwork and dealing with colleagues are given below.

> "Teamwork is at its best when sharing, and caring." (IS FP5 C1)

> "Dealings with colleagues are generally good, and occasionally bad. Difficult teaching colleagues will be difficult clinical colleagues." (PC FP4 C1)

Self-regulation: The study participants said that cultural differences play their role in how one informally self-regulate for alcohol, smoking and drugs. They mentioned variety of informal practices to regulate themselves such as, reflection and reflective writing, attending conferences, finding suitable training opportunities, peer feedback, reading and writing papers, and discussing clinical trials with colleagues to stay up-to-date. An example of representative statement for self-regulation is given below.

> "We have got appraisal and revalidation which is a framework that allows us to improve professionally. It's about reflecting and challenging appropriately, how people address educational needs, checking that they have addressed those needs that they have expressed. It's about multi-source feedback, how do people in your team, think you are, and how you behaved." (PC FP4 C1)

Role in society and conflicts: The study respondents reported that doctors are highly trusted by society. They may face some difficulties in keeping up this image due to overloaded healthcare system, which is leading to many internal and external limitations and conflict situations. The students and doctors agreed that they need more formal training in conflict resolutions, to enhance their skills to resolve conflicts. Examples of representative statements for conflict situations and resolution are given below.

> "Resolving conflicts is really difficult. 'Do you prescribe for yourself?', 'Is it alright to prescribe something simple and fairly benign like an antibiotic?' I know people who would think that actually that kind of thing is probably acceptable. Would you write a prescription for your colleague who asked you, without that being in the normal doctor-patient relationship? I think most people would agree that there are boundaries to that. For

example, simple analgesia, straight forward antibiotics, those kinds of things, they are no big deal. Then there are things that people would say, you should never prescribe for yourself, or family member, colleague, for example opioids, anti-depressants, benzodiazepines. And then I think there is kind of grey area." (SR FP1 C3)

"Conflict resolution is very context specific because an emergency situation is very different from a more elective situation. The first issue is to establish all the facts, and then start a conversation. Even the most complex situation can be broken down into its component parts for simplicity, and by working through things in a measured way with the usual checks and balances. You can usually find a solution or choice of pathways to address the most difficult situations with careful communication, and documentation." (AD FP2 C3)

Differences in perceptions across cases

In general

Culture of Excellence and Research: One medical school, with a strong history of medical education research, was more concerned and critical of its own setup and practices. I felt that this self-criticism to achieve excellence may be one of the reasons for the quality of that particular medical school in innovative medical practices. Another reason may be the interest of leadership in medical education, which also had influence on students, as they were more involved in medical education research, though not professionalism, in specific.

Size of the organization: The students of the largest medical school (which has multiple clinical teaching setups, some at other cities), experienced more variation in practice, as compared to students from other two Scottish medical schools. They appreciated how the size of a healthcare facility affects the professionalism of the staff, where small setups are better than the large hospitals. The observations were mostly related to 'dealings with colleagues' and 'team working'. The teams in small to medium sized setups were slightly informal and knew each other well, which had a positive effect on the overall environment of the workplace. The teams in larger hospitals were though professional in team working but they functioned in a formal manner. The students found larger setups more hierarchical as compared to medium to smaller setups, and therefore did not have good experiences in the large hospitals, as they felt lower in the medical hierarchy. One of the reasons might be the power dynamics, based on the medical knowledge. They also shared that though these observations of varied professional practices may be helpful in the early years

of practising medicine, but not at undergraduate level. One of the reasons, which they gave, was the adoption of different ways to communicate with patients or to clinically examine the patient, where some examination methods or communication styles were not considered as standard by other clinicians, from the medical school.

Openness: The third medical school was very welcoming for multi-centric studies. One of the advantages of variation seen in this medical school was that the students, who participated in the FGD, were from different cultural backgrounds, such as the USA, Middle East, UK, and Singapore. The student from the US was more satisfied with the Scottish healthcare system because he had some personal bad experiences in the US, and also because of the culture of legal suing in the US, as compared to the UK. The student from Middle East had an understanding of cross-cultural variations, and reflected on the role of doctors from Asia and European countries mentioning language as a barrier during communication skills for some European doctors. Similar difference was mentioned by a student from another medical school on the standards of the technical skills of a young European doctor, who could not draw blood from a patient, as drawing blood was the task of nurses in their country. The data suggested that the free movement of doctors across Europe has slightly affected the standards of healthcare at a few healthcare facilities in Scotland.

Students

No additional major differences in the perceptions of the students were identified, except that they had different stories to explain similar situations.

Faculty

Relationship of professionalism with experience: Some of the doctors were of the view that professionalism is at the belief level, whereas others perceived it at the behavioural level. Those suggesting professionalism at the belief level were senior clinicians who have written extensively on professionalism. The other group, who placed professionalism at the belief level, were the religious minded consultants for whom medicine is a ‘calling’. Those who placed professionalism at the behavioural level were tended to be the middle aged clinicians. This correlates with one of the

observations of the students that professionalism improves with experience. An example of representative statement is given below.

> "Professionalism relates to everything that the doctor does and everything that the doctor is and it's not a subset of what the doctor does or what the doctor is which is why it's difficult to capture. Professionalism isn't dressing up in a particular way on its own. It isn't communicating in a particular way on its own. It isn't being an upright and upstanding member of a society on its own. It isn't having a particular set of knowledge or values. It's the whole thing. So there are lots of descriptions of being a professional. Being a medical professional which is sometimes slightly different and more acute at times, involve attributes such as having moral courage, forming trusting relationships, acting for a common good, having a relationship of trust based on confidentiality, being altruistic, and all these type of attributes." (PC FP4 C1)

Influence of culture and religion: Two doctors, who have worked across both Pakistan and Scotland, mentioned the influence of culture on professionalism. One of the examples was the care of the elderly people, which is more in the Asian culture than in the Western culture, and has its roots embedded in the joint family structures in the Asian countries. Both these doctors also mentioned the role of religion and how it guides them to behave, and act in a professional manner. The role of religion was also evident in Pakistan. An example of representative statement for cultural difference in 'care for elderly' is given below.

> "There are a lot of cultural factors that interfere such as, the way you have been brought up, and trained. In general, human beings have similar conscious, for example, bad things will include lying, not looking after ill person, not thinking about humanity, and not looking after elderly people. So these are conscious things which I think have been emphasised in our culture. In the same way, it has also been emphasised in our religion. I remember when I first came to this country (Scotland); I was looking after elderly patients for a few days. I went so well with them that one of the patient's daughter came to me, and said that, 'there is a lot of cultural element to the way you are looking after my mother, because she was in hospital before as well. She was looked after very well but the way you are looking after is different'. So, I think, there are some cultural elements, which will make you a good professional doctor." (MFK FP2 C2)

Multiple case study results from three Pakistani medical schools

In this section of results, the intention is to answer the third question of this study, which is as follows:

- What are the cultural similarities and differences in understanding professionalism, within a country?

This section shows the cultural similarities and differences within Pakistan (Case 4, 5, 6). The sample size was 49, which included interviews from 21 clinical faculty members and three focus group sessions with 28 clinical years' students. The sample from Pakistan is slightly larger because of more variation in professionalism. The themes and sub-themes for faculty members, and students from three medical schools were triangulated, and are shown in Table 17 & 18.

Table 17: A summary of the faculty members' perceptions of professionalism from three Pakistani medical schools.

Core Theme	Themes	Sub-themes	Categories
Healthcare system	Dynamic		
	Approach to patient	• Context-centred	
	Teams, colleagues and other healthcare professionals	• Poor teamwork • Hierarchy • Less respect for other health professionals	
	Self-regulation	• Informal • Varies • Need for external regulation	
	Society and family	• Varied views of society • Cultural Elements	• Influence of religion • Low education • Gender influence • Difficulties with extended family • Social accountability
	Limitations and Conflicts	• Cross professional boundaries • Medico legal framework • Conflict in context • Conflict Resolution	• Mostly informal

Table 18: A summary of the students' perceptions of professionalism from three Pakistani medical schools.

Core Theme	Themes	Sub-themes	Categories
Need for training in communication skills and professionalism	Dynamic		
	Approach to patient	• Extreme variations in standard practice (System-centred)	
	Teams, colleagues and other healthcare professionals	• Hierarchical • Small group activities can improve interaction	
	Self-regulation	• Informal • Need for external regulation	
	Society and family	• Double standards of society • High views and expectations by family	• Negative views • High expectations • Blame doctors for weakness of the system • Gaps in delivered curriculum
	Private versus public medical school	• Difference in confidence of students	
	Limitations and Conflicts	• Conflict in context • Observation of unprofessional practices	

Triangulation between faculty and students' perceptions is done for a holistic picture to understand professionalism in Pakistan. Table 19 below shows the combined themes for professionalism from Pakistan.

Table 19: A combined summary of faculty and students' perceptions of professionalism from three Pakistani medical schools.

Core Theme	Themes	Sub-themes	Categories
Need for training in communication skills and professionalism	Healthcare system influences professionalism	• Dynamic	
	Approach to patient	• Extreme variations in standard practice (System-centred)	
	Teams, colleagues and other healthcare professionals	• Poor Teamwork • Hierarchical	
	Self-regulation	• Informal • Need for external regulation	
	Society and Family	• Varied views of society and extended family • High views and expectations by close family • Cultural elements • Social responsibility	• Influence of religion • Low education • Gender influence • Formal • Informal
	Limitations and Conflicts	• Conflict in context • Cross professional boundary, (may lead to unprofessionalism) • Mostly informal conflict resolution	

Similarities in perceptions across cases

Students

Variations in standards: The students from Pakistan reported extreme variations in standard practices, mostly dependent on the personality of a doctor, and the constraints of the system. They observed some doctors having different standards for patients from different strata of society. A rich patient who usually will go to a private hospital enjoys more respect, as compared to a poor patient who can only rely on already overburdened public sector hospital.

> "Usually in Pakistan the division is on basis of finances; one is poor and other, rich. You will be treated much better, if you are going to rich peoples hospital (usually a private hospital), where you pay lot of money. If you are going to some poor hospital, like 90% of government, or charity hospitals, then usually, you will not be treated well. I have observed bad scenarios in our charity hospital where the doctors did not behave properly with patients." (FGD S C5)

External regulation: They practice self-regulation informally however there is a need for strong external regulator to guide them. The students observed 'role modelling' as an inspirational factor for informal self-regulation. An example of representative statement is given below.

> "Strangely enough, we can self-regulate ourselves by actually letting good people be as our Heads. I can give you an example of our college. Our Principal just changed, and things are improving. I usually used to get late but now thankfully to our Principal, I am actually on time to school because he won't let us enter after 8:00 AM. So, I can self-regulate myself while letting good people on the top. There should be someone to regulate me if I don't self-regulate." (FGD S C4)

Views of family & society: The students said that their families have high expectations from them but society in general has double standards for doctors. However, they view medical students with respect due to their humanistic nature. An example of representative statement is given below.

> "We are highly regarded, right from the admission in medical college. They expect from us that we will treat them, and they also share with us their real problems as if we are real doctors. Even at this stage, as medical students, we are really respected." (FGD S C4)

Conflict situations: The students reported different conflict situations. The students in public medical school may have to call for extreme measure, such as strikes to resolve their conflicts with administration, whereas the students in private medical

schools are given proper hearing by the administration. An example of representative statement is given below.

> "Sometimes, an appeal doesn't work on administration, and the only option left is to 'strike'. And without this extreme measure, nothing happens. No one takes issues seriously until we call for a strike." (FGD Students C4)

Faculty

Decreased quality of training: The doctors showed their concern about the quality of training because of the increase in number of trainees per doctor, due to which the supervisors are not able to give enough time to each trainee. Moreover, they also mentioned that the trainees' interest is in knowledge and skills, so they can independently start a private practice to earn more money. They consider this a serious issue and a limiting factor for quality training. An example of representative statement is given below.

> "In our time, there were 5-6 TMOs (trainee medical officers) in one unit and now there are 20-40 trainees here. More workforces are available now but individual attention is less because the timings are the same. I was given an opportunity by my professor, for example, an hour a week to just council me, train me, and to help me in my career. I have to divide it now, say on receiving end, 10-20 minutes per week. Then their behaviour to attain training to have surgical skills might be better now but as a doctor, as a good human being, and as a good clinician, well, I think there are gaps that needs to be filled." (ZA FP7 C4)

Dealing with conflict situations: The faculty members reported that conflicts are mostly resolved informally through discussions. The doctors usually are not aware of the in-depth details about the medico legal framework of the country, due to which they find it difficult if any such case arrives at their clinic or hospital. This shows an importance of teaching of medico legal studies at both undergraduate and postgraduate level. An example of representative statement is given below.

> "Most of the time doctors work within their professional limits but as you can say, the medico legal issues in Pakistan, the legal framework is not as effective as in the developed countries. So due to the laxity of that legal or law implementation, sometimes a part of our community might lack in the aspect of dealing with conflict situations." (MFK FP2 C6)

Overall similarities in perceptions of faculty members and students

Stressed Healthcare system: The study respondents from Pakistan reported extreme variations in standard practices. They said that doctors in Pakistan are under tremendous stress because of the weak healthcare system. The reasons are enormous patient-overload, no appointment system, limited resources, no active primary care, no training of doctors for such situations, shortage of doctors and supporting health staff, etc. This leads to a doctor-centred approach, in which the doctors approach patients, keeping in view all the other factors. Moreover, the culture of running private clinics in the evening adds to further exhaustion and a burn-out. A representative statement for weak healthcare system is given below.

> "I myself am not satisfied that I am providing the best care that I should have been. So, experience is not that good but in our setup, it's not that bad as well. A doctor usually sees 150 patients in OPD. So, the rush, time constraint, and the load shedding; all these factors aggravate situation. I think everybody is almost, trying his best to provide care to patients. I may not be satisfied 100% but it will be somewhat 70-80%." (ZA FP7 C4)

Dealing with colleagues and teams: The study respondents stated that most of the doctors show courteous behaviour towards colleagues but some of the doctors and medical students are quite unsocial, and do not interact with their colleagues. Teamwork, in general, is perceived to be unsatisfactory and hierarchical. The intra-team activity in some wards may be good, but the inter-team and multi-team work is judged as unsatisfactory. A representative statement for poor multi-teamwork activity is given below.

> "Probably, we have to work a lot in this area to improve as a team. A majority of us (doctors), at least here in this part (Peshawar), we work individually. Currently, I am working on a project to develop at least a tumour board meeting for the city. I bring in the oncologist doctors and radiology therapist and they treat the patient as a team. However, teamwork is an area which we are lacking." (MT FP4 C5)

Informal self-regulation: The respondents reported lack of formal framework for self-regulation due to which, the standards of practice vary. They were of the view that self-regulation needs to be imposed by an external regulator for standardization of practices, and for the development of professionalism. A representative statement is given below.

> Any doctor who is not regulating himself is not a professional. I have learned medicine and the practice of it through self-assessment and self-monitoring. I have always questioned my approach, and I have always analysed my attitude towards

> people, and wherever I found; any shortfall, I have tried to address it. Sometimes the answers are simple and I find them by myself. However, there are occasions when you have a situation, and no straight forward answer is coming up, then you can always discuss it with your colleagues and with discussion, something positive comes up. (IHS FP5 C5)

Image of a doctor in society and family: The faculty members said that society has varied perceptions about doctors. In general, the society trust doctors but due to low education and cultural elements such as approach of males towards females, the approach is formal and conservative. Some male doctors may have difficulties in communicating with female patients, who are shy to talk to a male. This suggests the importance of training in communication skills in the local context. Some doctors said that at times, there might be difficulties with extended family members, and some of them have same perceptions, as that of a society. The reason is that they do not understand the nature of the job of a doctor, and his life style. An example of representative statement is given below.

> "If you are a specialist doctor, still everyone will expect that you have to give them certain advice or at least guide them. I will give an example of my spouse, she is a pathologist and whenever she goes to our village, every woman comes and asks about gynaecological problems. Those women think that every woman doctor knows and can treat the gynaecological problems. Therefore, in our case, low education level in the society is an issue. They think that every doctor knows everything about the disease, and they expect a lot from you." (MT FP3 C5)

Conflict situations and resolutions: The study respondents reported that there are doctors who may get involved in unprofessional practices especially in the private practice, or while practising in periphery stations. The conflicts are mostly resolved informally, as there is no training or defined structure for conflict resolution. There is less awareness about professional limits and legal boundaries, and training is required to resolve conflicts and to be aware of professional and legal limitations. The study respondents agreed that because of lack of formal training in professionalism, the faculty and students get into difficult situations. Moreover, the training in communication skills is not focused in both undergraduate as well as postgraduate medical programmes, which is another factor for a downfall of professional image. A representative statement is given below.

> "There have been many conflict situations but I don't think that we have sufficient training to deal with them for example, a patient not giving consent to examine him. Then I don't have the adequate knowledge and skills to convince that patient, to examine him. So, I think, we should be taught how to deal with situations like that." (FGD S C5)

Differences in perceptions within Pakistan

Some of the differences that emerged by comparing single case studies from Pakistan are reported here.

Public versus private medical schools: The Case 4 was a public sector medical school affiliated with a public sector medical university from the KP Province. The students, who score highest in the merit list, usually join this medical school. The other two medical schools, Case 5 and 6, are from private sector, one from KP province and another from Punjab province, and are affiliated with a private university. The private medical schools had more innovative curricular strategies, stronger department of medical education, and more research activities going on, as compared to the public sector medical school. However, the data suggested that despite being innovative, the private medical schools still failed to build confidence in their students, which is an important factor for professional identity formation, and hence professionalism.

The students from the two private medical schools mentioned that society perceived public sector medical school students with more respect. The reason is that the public medical school students have higher merit than private medical school students. Moreover, the private medical school students pay high fees to get into the private medical schools. An example of representative statement is given below.

> "Even in the medical schools, there is discrimination between private and public. If you get in private, people think that you didn't get admission in any of the public medical school so you joined private. Another thing about private is that you buy degree by paying money." (FGD S C6)

Distance between the medical school and the teaching hospitals: The distance and movement between medical school and teaching hospital was one of the stress factors for one private medical school, as its teaching hospital was quite far from the medical school. The clinical faculty members found it difficult to cope with the new curricular activities with enhanced integration where they also had to leave their clinical duties, and had to deliver clinical lectures to basic years' students, and frequent activities at medical school. The clinical faculty felt more stress while spending more time on travelling, which was indirectly affecting their professionalism, as they had to provide services to their patients in a limited time.

The public sector medical school had an advantage that its teaching hospital was at close walking distance, and none of the faculty mentioned distance between medical school and teaching hospital as a stress.

Size of the organization: The data suggested that the size of organization affects its efficiency, administration, and student interaction. The small and medium size organizations can perform much better than big organizations. This is one of the reasons that the public sector medical school, Case 4, which is the biggest organization is slow to respond to the professional needs of today's students, while the private medical schools, which are much smaller in size, are more efficient in bringing reforms to meet the professional needs of the students.

Ideology of the organization: One of the private medical schools (Case 5) had a religious ideology, which was a driving force for their excellence in research and professionalism. This medical school is just eight years old and is still managed by its founding team, which is one of the reasons to follow the ideology on which the medical school was built. The other medical schools (Case 4 and 6) may also be following an ideology to some extent but not with the same zeal, and are mostly driven by the market forces.
The faculty and students in this medical school (Case 5) were driven by the Islamic form of professionalism, which are the qualities of good human beings with guidance from Islamic teachings. The medical school teaches professionalism through their own research book in which they have linked forty religious statements with criteria for a Muslim doctor, which in the West, is identical to the model of a 'good doctor'. The statements cover most of the aspects of Western evidence-based research on criteria for medical professionalism. The advantage of using such format of teaching professionalism is to align students' internal beliefs with modern day research, which drive them towards achieving excellence in professionalism.
However, my observation was that the medical school was still not able to decrease the gap between the formal and informal curriculum.

Conflict resolution: The students in the public sector medical school reported that they have to take extreme measures, such as a call for strike, to resolve their issues with the university or school administration. The need to adopt extreme measures

was not mentioned by students in private medical schools. The reason may be that the administration of private medical schools is more responsive towards their students' needs compared to public sector medical school.

Service structure for doctors: The students from Case 6 (medical school in Punjab province) mentioned that 'lack of service structure for doctors' is one of the factors that may lead doctors towards unprofessional practices. This was not mentioned by the students from Case 4 and 5; both in the KP province. The reason may be that the Young Doctors Association (YDA) is more active in Punjab province, pursuing government to implement service structure for doctors. An example of representative statement is given below.

> "The problem here is that we don't have any service structure for doctors. A doctor has to look after his family. If he talks about his pay, people will definitely say that he is selfish and only cares about his pay, and does not care about the humanity and the people who are dying. In our setup, people consider them as Messiah or angel. They take them as machines whose only job is to save humanity. They do not consider his personal life and responsibilities towards his family. This factor has aggravated the problem." (FGD S C6)

Section 3: Multiple case study results from Scottish and Pakistani medical schools

In the third section of the results, the objective is to answer the fourth question of this study, which is as follows:

- What are the similarities and differences in professionalism across cultures?

A total of 36 clinical faculty members were interviewed and six focus group sessions were arranged with 51 clinical years' students, from six medical schools forming a total sample size of 87 respondents. This section shows the similarities and differences in understanding professionalism across Scotland and Pakistan. A comparison has been made between two countries, in the form of commonalities and differences according to the contexts. The themes and sub-themes for faculty and students from six medical schools were triangulated and are shown in the Tables 20 & 21. Moreover, further triangulation between faculty and students from both countries is done for a holistic picture of the understanding of professionalism in both Scotland and Pakistan. The combined results are shown in Table 22.

Table 20: Cultural similarities and differences between clinical faculty's' understanding of professionalism across Scotland and Pakistan.

Core Theme	Theme	Scotland	Pakistan
Healthcare System (System-centred approach)	Professionalism	• Dynamic	• Dynamic
	Roles	• Morals • Guidelines • Culture • Limitations	• Morals • Guidelines • Culture • Limitations (+/-)
	Approach to patient	• Context-centred	• Context-centred
	Dealings with colleagues, teams, and other healthcare professionals	• Context • Flat hierarchy • Shared leadership • More respect for other health professionals	• Poor teamwork • Strong Hierarchy • Positional leadership • Less respect for other health professionals
	Self-regulation (SR)	• Hallmark of professionalism • For public's interest • Criticism of formal methods • Informal	• No formal methods • Variation in Informal SR • Need for external regulation
	Image of a doctor in Society and Family	• Mostly respected, but some unusual perceptions and expectations of society • Family has high expectations • Cultural Elements	• Varied views and expectations of society • Family has high expectations • Cultural Elements
	Limitations and Conflicts	• Manage conflicts according to context • Unusually cross professional boundaries • Clear medico legal framework • Mostly informal conflict resolution	• Manage conflicts according to context • Usually cross professional boundaries • Most doctors not very familiar with medico legal framework • Mostly informal conflict resolution

Table 21: Cultural similarities and differences between students' understanding of professionalism across Scotland and Pakistan.

Core Theme	Theme	Scotland	Pakistan
Healthcare System (System-centred approach)	Professionalism	• Dynamic	• Dynamic
	Roles	• Appropriate behaviour according to different roles	• Appropriate behaviour according to different roles
	Approach to patient	• Context-centred • Usually satisfactory	• Context-centred • Usually not very satisfactory
	Dealings with colleagues, teams, and other healthcare professionals	• Context • Flat hierarchy • Trend towards shared leadership • More respect for other health professionals	• Poor teamwork • Strong Hierarchy • Positional leadership • Less respect for other health professionals
	Self-regulation (SR)	• Formal & informal	• Informal • Need for external regulation
	Image of a doctor in Society and Family	• Mostly respected, but some unusual perceptions and expectations of society • Family has high expectations • Cultural Elements	• Varied views and expectations of society • Family has high expectations • Cultural Elements
	Private versus public sector medical school	• No private medical school	• Difference in confidence of students
	Limitations and Conflicts	• Manage conflicts according to context • Have not observed any unprofessional practice • Mostly informal conflict resolution	• Manage conflicts according to context • Observation of unprofessional practices • Mostly informal conflict resolution • Male students more understanding and better in conflict resolution than female students

Table 22: Cultural similarities and differences between faculty and students' understanding of professionalism across Scotland and Pakistan.

Core Theme	Theme	Scotland	Pakistan
Healthcare System (System-centred approach)	Professionalism	• Dynamic	• Dynamic
	Roles	• Appropriate behaviour according to different roles keeping in view morals, guidelines, culture, and limitations	• Appropriate behaviour according to different roles keeping in view morals, guidelines, culture, and at times limitations
	Approach to patient	• Context-centred • Usually satisfactory	• Context-centred • Usually not very satisfactory
	Dealings with colleagues, teams, and other healthcare professionals	• Context • Flat hierarchy • More respect for other health professionals	• Poor teamwork • Strong Hierarchy • Less respect for other health professionals
	Self-regulation (SR)	• Formal & informal • Criticism of formal methods	• Practiced informally • Need for external regulation
	Image of a doctor in Society and Family	• Mostly respected, but some unusual perceptions and expectations of society • Family has high expectations • Cultural Elements	• Varied views and expectations of society • Family has high expectations • Cultural Elements
	Private versus public sector medical school	• No private medical school	• Difference in confidence of students
	Limitations and Conflicts	• Manage conflicts according to context • Have not observed any unprofessional practice • Mostly clear about medico legal framework • Mostly informal conflict resolution	• Manage conflicts according to context • Observation of unprofessional practices • Most doctors not very clear on medico legal framework • Mostly informal conflict resolution

Table 23 shows some of the major reasons for variation in professional practices across both countries.

Table 23: Reasons for variation in professional practices across both countries.

Reasons	Examples
Individual/Personal	• Variations in training of professionalism, self-regulations, and communication skills. • Difference in workload conditions • Multiple roles to play • Balance between personal and professional life • Generational difference
Speciality Area/Field	• High-pressure versus low-pressure situations for example, A&E versus Radiology • Nature of speciality such as Medicine versus Surgery
Workplace situation	• Size of the workplace for example, small workplaces had better coordination than larger teams • Colleagues at the workplaces, inter-personal relationships • Senior's attitude or Leader's role • Nature of the workplace such as GP practice versus hospital setup • Transitions periods, that is, during a change time, there is a performance dip. • Teams which work in more variety of workplaces, have better coordination, and adjust quickly, such as Surgery, working across wards, OPDs, OTs, and A&E.
Organizational and national level	• Promotion of culture of excellence, quality, and professionalism on institutional level, and by national regulatory bodies.

Overall similarities in perceptions of faculty members and students

Influence of healthcare system on medical professionalism: The study respondents from both countries reported that professionalism is dynamic and is dependent on how a doctor works in a specific healthcare system. All the study respondents appreciated the importance of 'context' specific nature of medical professionalism and mentioned that professionalism is not absolute, but relative, adjusted according to the situation. In the UK, GMC represents the views of the society and guides doctors about them in the form of documents such as 'Tomorrows Doctors', and 'Good Medical Practice', whereas in Pakistan, no such document is provided by the PMDC. It was found that the expectations of society across both countries are similar, such as respect, courtesy, and approachability. This suggests that the demands of society across both countries are similar, and therefore similar attributes of professionalism are required from a doctor. Thus, there are some core

attributes of professionalism which are common across both cultures, while the context can be different even for the same doctor on the same day, with two different patients. The analysis showed that society has conservative views about doctors and they expect doctors to be conservative, and to take medicine as a vocation. A representative statement for the influence of healthcare system on professionalism of doctors is given by a doctor from Pakistan.

> "I will explain the influence of healthcare system on professionalism of doctors with help of an example. In the informal chat right now, I was talking about the T20 match, 50 overs match, and test match format of cricket. The batsman knows that the shot which he is playing, if he has five days test cricket, he can make a century, He can be a match winner and he is not going to make a mistake, and invariably, in test match batsman always gets out because of his own mistake. In the 20 overs or 50 overs format, he gets out and he knows that the shot was not upto the mark, it was not a professional shot, it wasn't the shot of a cricketer but the format of the game is such that, he has to compromise the gold standard of test cricket, which some people say, 'is the real cricket'." (IK FP3 C4)

Curriculum, teaching and assessment of professionalism: The respondents mentioned the importance of the role of both formal and informal curriculum, and the difficulties in teaching and assessment of professionalism. The students from Scotland said that doctors in their teaching roles should be approachable for informal feedback and advice. They also mentioned alignment issues in standardization of doctors as assessors. Different doctors have different approaches when they are assessing students on stations of communication skills. The three medical schools from Pakistan reported different curricular strategies however the students reported almost identical responses. One explanation for this could be that although the curricular strategies were different, still the focus was on scientific knowledge. Moreover, the study findings showed gaps in the formal and informal curriculum in all three medical schools. It was also observed that some of the clinicians still consider the traditional curriculum better than the innovative curricular strategies. Three representative statements by faculty members and students are as follows:

> "Professionalism improves with experience. We explicitly teach it using peers to teach professionalism and through role modelling scenarios." (JM FP2 C1)

> "Simulated observation in exam situation is not the true reflector of professionalism." (PC FP4 C1)

> "Assessing communication skills in snapshot (station) is not true reflection of the communication skills." ((FGD S C1)

Roles: The study participants reported that professionalism signifies a doctor to perform well in different roles and to show the appropriate behaviour according to the role. The respondents mentioned the idea of compartmentalization of

personality for different roles. They mentioned that the doctors should be aware of the limitations of different roles and should take the best decision for patient safety, according to the context. However, there can be difficulties in a constrained and under pressure situations. The different roles of a doctor depend on moral values, culture, and guidelines by the organizations and regulatory bodies.

The respondents mentioned that the most important level of interaction for professionalism is individual dealings with a patient, after which comes the role of a hospital, and then the broader healthcare system and culture. The key in patient-doctor relationship is the one-to-one meeting. Therefore the focus needs to be on developing skills for one-to-one interaction with patients. The relationship of patients' interaction and the level of importance are shown in Figure 28.

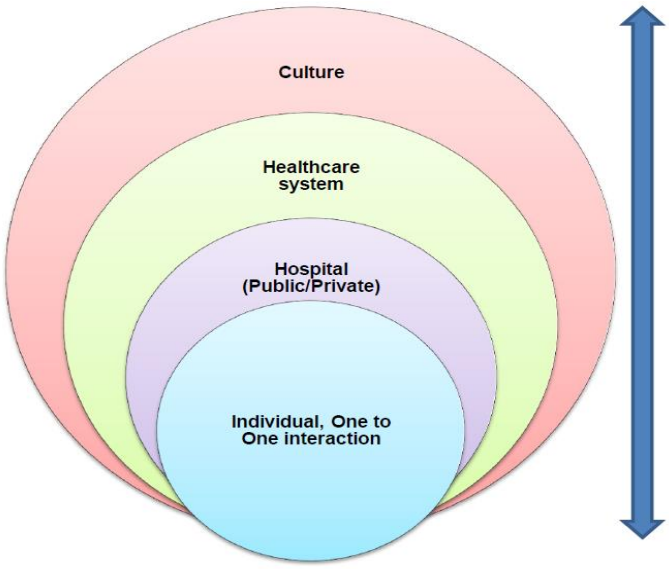


Figure 28: The interaction level of the patient with the healthcare system and culture.
The innermost circle is the most important in patient care followed by the subsequent circles. The arrow on the right shows the overall levels of interaction of a patient from a culture towards the individual doctor.

Some of the representative statements, shared by faculty members and students are as follows:

> "It's actually a multi-dimensional construct which has different levels, that is, individual professionalism, professionalism at the interface where you interact with your colleagues and patients, and the institutions that you work in. Then, there is the wider professionalism which is professionalism to the medical society, and how it interacts with the wider society." (JG FP3 C1)

> "I think that part of being professional is recognizing their limits, recognizing whether you are competent in something or not; where in context you should be dealing with it or you shouldn't. I think that's part of being professional, and there are people, particularly younger doctors who are just starting in, get quite excited by the idea of the power of medicine and being able to intervene. So, they might do more than they should. As you grow older, you realize that being a

> professional is recognising that you don't really know all the answers, you don't have all the skills. You shouldn't do something that might make it worse. You recognize your own limitations, and you pass on to someone who is competent to deal with it. So, I think on the whole doctors work within their defined limits. There are very few exceptions and sometimes it's contextual rather than an underlying bad attitude." (JG FP3 C1)

Approach towards patients: The study respondents stated that the ideal practice is 'patient-centred approach' in which, the patient as a person is the focus. The idea is to empower the patient for their own health. However, due to other imposing factors, such as workplace condition, resource constraints, and time limitations, it is mostly context-specific approach, where the doctor is more sensitized to the context. The study participants agreed that professionalism is reflected in the behaviour of the doctors. 'Empathy' was a common professional attribute across faculty and students, from both the countries. The students in both the countries mentioned few doctors to be judgemental towards patients, whereas the faculty members did not mention it. The reason can be that the doctors do not realize when they are being judgemental towards the patient, but a medical student could observe. 'Being judgemental' might be mostly the 'blind self' of a doctor, which they are not able to appreciate, but is visible to the students (121). Some of the representative statements shared by faculty members and students are as follows:

> "Approach empathetically. Ideally, doctors should be non-judgemental. They should listen carefully, provide privacy to patients, offer treatment options to patients, and should communicate respectfully according to context." (FGD Students Case 1)

> "I think the overwhelming philosophy that I certainly have is that, at the end of the day this is about patient-care." (RJ FP4 C2)

> "Doctors are becoming very task focused rather than person focused. I recently had a friend who has been ill and I had been going as a visitor and a carer, to see him in the hospital. My only observation is that he is being seen as an illness or as a task, a series of different tasks to do rather than as a person." (JK FP1 C2)

Dealings with colleagues, teams, and other healthcare professionals: The students and doctors agreed that because of the lack of training, teamwork is weak, but the surgical teams work better than the medical teams. The explanation may be due to the frequency of working in a team in a changing workplace, for example, OPDs, wards and OTs, with multiple small teams within every OT. On the contrary, Medical ward doctors usually work in wards or in OPD, and share less workspaces. Moreover, the nature of surgical team is multi-disciplinary, while in medical wards, the medical specialists can manage most of the treatment and management plans individually.

The study respondents agreed that high-pressure situations can negatively affect teamwork. Some staff members may become aggressive or overburdened, which may lead to unprofessional behaviour. Examples of representative statement are given below.

> "There are variations in dealing with other healthcare professionals and depends on the individual person." (IS FP5 C1)

> "Doctors, by and large, treat other healthcare professionals as equal and value them as healthcare team. Dealings with colleagues are generally good, and occasionally bad. Difficult teaching colleagues will be difficult clinical colleagues." (PC FP4 C1)

External regulation and self-regulation: The external regulator has an important role in imposing self-regulation, and to make sure that the process and instruments used are fit for purpose. Variety of informal practices are used by both doctors and medical students from both countries to regulate themselves such as, reflection, conferences, finding suitable training opportunities, peer feedback, and reading papers to stay up-to-date. Two representative statements for self-regulation are given below.

> "If you believe that medicine is about patients, and patients are the public then the public must have a role particularly within the healthcare system where you socialize medicine like in the UK. So what I concern about external regulation is that it's driven by politics or by market forces but I think that there must be a significant element of public input into the regulation of doctors. Doctors are not always the best guides to doctors, to what a doctor should be doing. I think we are not priesthood because I don't think we should be. So, I am not comfortable with the concept of complete self-regulation. I think there is necessarily a spectrum so it goes from a complete self-regulation all the way to complete external regulation. The correct way of regulating doctors behaviour is probably somewhere in the middle." (AT FP5 C3)

> "The culture is also going to play its role in how you self-regulate yourself. Things like alcohol, smoking, drugs will be different depending on cultural beliefs." (FGD S C3)

Image of doctor in society: The respondents agreed that doctors are highly trusted by society. They said that they have to maintain the image of a doctor in the rapidly changing society. There were concerns over the negative role of media which is damaging the image of a doctor in society. They said that doctors are a slice of society, and should be recognised as professionals, and not Messiahs. A representative statement for image of doctor in society is given below.

> "It's always known that the society has a judgement upon doctors so when you take a choice to go for a career in medicine, you are taking all that on board. So you can't use an argument of 'I will do what I do at my own time'. You chose the routine that comes with the career. You have to be willing to adopt yourself to that part of the career which is society's impression of you. So when you take on this job, that's just it. Society is always going to have an impression that's never going to change so you have to adopt yourself to what society see you to be." (FGD Students C3)

Limitations and conflicts: Identifying the professional and legal limits, and dealing with conflict situations was considered as a weak area and all the study respondents said that they need more formal training in conflict resolutions to enhance their skills. The students and faculty members from both countries mentioned some grey areas where medicine and law are not congruent, which lead to dilemmas in clinical practices.

> "There will be an action which seems to be ok, but legally, it may not be. A general case will be a 16 year old girl in medical unit and comes with pain which can be headache. But you realize, this is not a headache, it's a pregnancy. In Pakistan, by law, you should inform the authorities. 'But do we tell the law?' No physician will do that in Pakistan, the only thing which we can do is to tell the parents but we will never involve the law. So there may be issues whose legal translation may not be legal from physician point of view." (AAJ FP9 C4)

> "At the end of the day, it's always the patient at the centre of the care. So, as long as that is kept in mind, I think the bigger picture all goes around that." (RJ FP4 C2)

Similarities in perceptions across countries

Students

The students mentioned different criteria for professionalism, which I have categorised as 'dynamic'. The students from Pakistan and one student from Scotland (who worked as a nurse in private clinic) reported observations of different professional standards in the public, and the private sector. The approach to patients in the private sector is usually for monetary gains. Moreover, the approach towards junior staff in private sector is more disrespectful, as compared to the public sector. They emphasized on more training in communication skills, and said that weak communication skills are one of the main causes for litigation, and conflicts. Students from both countries said that appearance of a doctor and standard of dress is considered an important factor in being a professional. Table 24 shows an example of a similar type of statement by a Pakistani and Scottish medical student, for the same theme.

Table 24: Example of similar statements by the students from across the two countries.

Theme	Scotland	Pakistan
Person-centred approach	"lot of medicine is not just treating illness, it's treating the person" (FGD S C1)	"It is like, you just not treat the disease but you treat the patient." (FGD S C4)

Faculty

The views of doctors from both countries were the same, when they were sharing their perceptions about professionalism related to practical issues. Representative statements are compared in Table 25.

Table 25: Similar statements between a Pakistani and a Scottish doctor regarding satisfaction and interaction with society.

	Pakistani doctor statement	Scottish doctor statement
Satisfaction	"I may not be satisfied 100% but everybody is trying and to what capacity he can do it. I am not satisfied 100% but it will be somewhat 70-80%." (ZA FP7 C4)	"I think there is no recognition that we are not perfect, mistakes will be made, and the nature of the relationship is fiduciary rather than altruistic." (JG FP3 C1)
Medical model considered as a limiting factor to interact with society	We spend our whole life in medical model; know some things about mental processes but sociology, societal forces, dynamics in society, are such things about which we doctors have very limited knowledge. (IK FP3 C4)	One of the problems with the lot of ideas of professionalism is that they are very medical in model. I don't think that the medical model fits for me, in the context I work. The medical model inhibits the interaction between the doctor and the patient. (JG FP3 C1)

In these examples, the doctors from both countries recognize that mistakes are made due to many factors and constraints, and ideal professionalism is not possible. In the second example, both the doctors mentioned medical model as a limiting factor in their interaction with society and patients.

The senior doctors across both countries appreciated that the views of society, about doctors, have changed over the past two decades. Doctors are now considered more accountable. They said that electronic and print media has a major role in changing the perceptions of the public. It can also be argued that the electronic and print media reflects the views of the public about doctors, which the patients cannot share in a face to face interaction with their doctor, because of their vulnerable and weak status. They reported that some of the consultant doctors still use their trainees as a labour workforce in both the countries, and look down upon them. The faculty members reported that patients' autonomy is respected in both countries, in accordance with the first principle of ethics.

Differences in perceptions across countries

In general

Understanding professionalism: The data showed that in the UK, the healthcare system and the GMC have standardized the culture of medical education and consequently there is not much variation in the perceptions of the faculty members and students. Their views were realistic, and they recognized that, professionalism does not mean perfection. In Pakistan, few doctors had idealistic views about professionalism following the religious model. An example of opposite statements by a Pakistani and a Scottish doctor are given in the Table 26.

Table 26: Versus (opposite) statements by a Pakistani and a Scottish doctor.

Pakistani doctor views on professionalism	Scottish doctor statement
"I would expect a perfect standard of his code of ethics or discipline or his practises when I am talking about 'professionalism and a doctor'." (SSA FP4 C4)	"I think there is no recognition that we are not perfect, mistakes will be made, and the nature of the relationship is fiduciary rather than altruistic." (JG FP3 C1)

Type of leadership: In the UK, the concept of shared leadership is emerging. The leader of a team changes with expertise and may not always be the consultant. In Pakistan, the structure of teams is still hierarchical and the leader of the team is always a consultant. An example of representative statement for type of leadership is given in table 27.

Table 27: Type of leadership in health professions teams in Pakistan and Scotland.

Positional leadership in Pakistan	Shared leadership in Scotland
"The team leader in this setup is generally a consultant physician. It is something that still remains in this part of the world. The nurses still have lower role in getting on with clinical setup in Pakistan. As they say, hierarchal setup in Pakistan in which the captain of the ship is the consultant and that's where the orders come from." (AAJ FP9 C4)	"The historical model is that doctors are completely in charge, and we all know that, it is much less the case than it used to be. There is a lot more ethos and shared ownership or shared leadership - or more accurately, the leader of the team is one who is most appropriate to lead that team, quite often, it will be a doctor but that need not be the case." (AD FP2 C3)

Ethics as core for professionalism: In Scotland, the students and faculty in this study were not as explicit in mentioning 'ethics' as core for professionalism as they were in Pakistan. However, in Scotland, they consider ethical practice as an important component of professionalism. This could be an example in which not discussing something (ethics here) does not reflect its lack of importance. Knowledge, skills, and ethics, which form the core of professionalism in Pakistan, are practised with religious values. Moreover, there is a difference in 'value for research'. In the three

Scottish medical schools, research is supported and valued more than in the three Pakistani medical schools. A representative statement for ethics as core for professionalism by a Pakistani doctor is given below.

> "A patient is a human being who is in pain and not well. This person is representing society. He has some responsibilities towards those people who are influenced by him, and affected because of his illness. So, he should be appropriately treated. That's where the universal four pillars of ethics come in. These four pillars should be rooted deep in a doctor, that is, he should be able to respect the autonomy of the patient, confidentiality, justice and non-beneficence. So this is my definition of, or understanding of a professional doctor." (IK FP3 C4)

Social status of patients: In Scotland, the data suggests that, all patients are equally respected but in Pakistan the social status of the patient defines the level of protocol that s/he will have in the hospital. The phrase, 'protocol culture', was most commonly used in the three Pakistani medical schools. A representative statement by a Pakistani student for social status of patient is given below.

> "Usually in Pakistan the division of patients is on basis of finances; one is poor and other, rich. You will be treated much better, if you are going to rich peoples hospital (usually a private hospital), where you pay lot of money. If you are going to some poor hospital, like 90% of hospitals, government hospitals or charity hospitals, then patients will be treated like, not well. I have observed bad scenarios in our charity hospital where the doctors did not behave properly with patients." (FGD S C5)

Self-regulation: The respondents from Scotland mentioned cultural differences and how they play their role in self-regulation with respect to their image in society and, for instance, alcohol, smoking and drug habits. In Pakistan, self-regulation was mainly practised with respect to cultural issues, such as the influence of religion, low education levels of society, gender influence, difficulties with extended family, and social accountability. A comparison of representative statements for influence of culture and religion on self-regulation is given in table 28.

Table 28: Influence of culture and religion on self-regulation of health professionals.

Representative statement from Pakistan	Representative statement from Scotland
"For self-regulation, I use to do self-accountability. It's a Hadith (religious quote) that at night when you are going to bed, think on what you have done in 24 hours. So, self-accountability is very important." (SA FP3 C5)	"Culture is also going to play its role in how you self-regulate. Self-regulation for things like alcohol, smoking, and drugs will be different depending on cultural beliefs." (FGD S C3)

Gap between formal and informal curriculum: The gap between the formal and informal curricula was greater in Pakistan than Scotland. It is evident from the literature that most of the learning of professionalism is through informal curriculum (11), which may lead students in Pakistan learning more about usual practice as

compared to the ideal practice. Moreover, I realized from the data analysis that the gap between the usual (context-centred approach) and the ideal (patient-centred approach) practice in Pakistan is greater than in Scotland. This may, again, be related to the culture of standardization in Scotland which is more efficient than in Pakistan. An example of representative statement by a Pakistani doctor for gap between ideal and usual practice is given below.

> "Professional doctors approach patients with confidence and empathy. They should not take patients as their commodity. However, the usual practice is different for trainee, house officer, and consultant. The consultants are in haste and the problem is the workload. The OPD timings are from 8 am to 1 pm, and there are 150-300 patients. So, they can hardly give 30 seconds to each patient. It's very difficult to explain or council a patient in 30 seconds. Hence, workload is the main issue." (SA FP3 C5)

Limitations and conflicts: In both countries, students and doctors are aware of conflict situations but there is difference in how they are resolved. In Scotland, issues are usually resolved through some formal procedure and also informally. In Pakistan, doctors and students find it difficult to resolve conflicts because of lack of training in conflict resolution. An example of representative statement by a Pakistani doctor for conflict resolution is given below.

> "Unfortunately, there is no defined clear cut structured framework for conflict resolution. It is usually from one incidence to another which arises, and then resolved by mutual consultation without any framework. I would consult another colleague but again that's on my own. There is no institutional process through which I can resolve my issue. It's one person to another person to third person, that they have a consultative process which is because of our social value that we have developed; not because that we have a structure for it." (NUH FP6 C5)

Students

The students from two Pakistani medical schools observed 'role modelling' as an inspirational factor for informal self-regulation but it was not mentioned by the students from the Scottish medical schools. However, not mentioning it does not mean it would not be regarded as important.

Faculty

Treating family members: In the UK, it is strongly recommended for doctors not to treat their family members and this recommendation is routinely followed because of the standardized healthcare system, strong primary care and referral system. In Pakistan, the doctors appreciate the fact not to treat their family members as it also

creates tensions for them but because of the weak healthcare system, and without any primary care and referral structure, they have to treat their family members although they try to avoid it as much as possible. An example of representative statement by a Pakistani doctor for treating family members is given below.

> "One of our relatives came to me for treatment with very advanced stage breast cancer with liver metastasis and the outcome was not very good. I tried to refer that relative to another oncologist for treatment but they refused and thought that I was trying to avoid them. I explained why I was doing that; they just couldn't realize why I was doing that so I had to take that patient. So, this is the problem which comes in cultural context that for good medical practice, as far as the UK is concerned, you shouldn't be treating your near and dear friends or family members. However, when it comes to Pakistan, being a family member, it is expected of you that you should be treating them, as a matter of their moral right on you." (AJ FP2 C4)

Role of teaching in self-regulation: The clinical faculty members in Pakistan considered teaching as an informal way of self-regulation and to keep up-to-date. None of the faculty member from Scotland mentioned 'teaching' as an activity for self-regulation to stay up-to-date. This might be that teaching is one of the mandatory jobs for most of the clinical consultants in Scotland. However, in Pakistan, it is only limited to the clinicians who are either at medical schools or in teaching hospitals. An example of representative statement by a Pakistani doctor for teaching is given below.

> "Teaching is very good way of keeping up-to-date. You have to know what's going on in your field, so that's a part of my regular work. Actually major part of my work is teaching so that's where I look at how others outside Pakistan are doing something, how they for instance approach this particular problem or challenge. We study it and analyse it according to our own setup." (AAJ FP9 C4)

Summary of the results

This study included interviews from 36 clinical faculty members and six focus groups with 51 clinical years' students, from six medical schools forming a total sample size of 87 respondents. The study showed similarities and differences in understanding professionalism across Scotland and Pakistan. Mostly there were many similarities in professionalism because of the influence of the UK medical education on Pakistani medical education. The few differences were due to the sociocultural variations and constraints of the healthcare system. These similarities and differences extended over nine themes; the nature of the healthcare system, curriculum, teaching and assessment of professionalism, roles of professional doctors, approach towards patients and other healthcare professionals, working in teams, self-regulation, image of doctors in society and within families, and dealing with ethical dilemmas and resolving conflict situations in the work place.

The similarities included the dynamic nature of professionalism in both countries due to the complex adaptive nature of the healthcare system. The respondents from both countries reported that appropriate behaviours are required with respect to morals, guidelines, and sociocultural constraints. Professionalism requires a doctor to be aware of his/her limitations as a practitioner, researcher, and manager. The approach towards patients is mostly context-specific in both countries, influenced by the time and available resources. Self-regulation is considered as a hallmark of professionalism. The informal methods of self-regulation in both countries were mostly similar. Doctors keep up-to-date by attending workshops and conferences, writing research papers and reflective portfolios, and informal feedback from colleagues and peers. Both groups confirmed that society has conservative views about doctors. They also mentioned a need for training in resolving conflicts, as these were mostly resolved informally.

The differences in understanding professionalism extended through roles, teamwork, formal self-regulation practices, sociocultural aspects, and law. The respondents from Scotland were clearer about the limitations of their roles as compared to respondents from Pakistan. This was mainly due to the explicit guidelines for doctors in Scotland set out in Tomorrows Doctors, Scottish Doctor, Doctors in Society, and

Good Medical Practice. The respondents reported that teamwork in Scotland was more efficient than in Pakistan. In Scotland there were flat hierarchies in teams as compared to Pakistan where the respondents reported a strong hierarchy. The respondents from Scotland reported that they observe and follow the concept of 'shared leadership' whereas in Pakistan, mostly the 'positional leadership' was followed. The respondents from Scotland reported observing more respect for other healthcare professionals compared to Pakistan. This was mainly attributed to the competency, knowledge and skills of other healthcare professionals, and showed better training of other healthcare professionals in Scotland as compared to Pakistan. In Scotland, the GMC formally evaluates doctors for their self-regulation by methods of appraisal and re-validation whereas in Pakistan, the PMDC has not yet introduced a formal assessment for self-regulation. Some of the sociocultural differences included treatment of the family members and breaking bad news to a patient. The respondents from Scotland mentioned that they do not treat their family members to avoid conflicts. However, in Pakistan, because of the weak healthcare system and unavailability of the GP system, the doctors usually have to treat their family members despite their wish of not treating them. The respondents from Scotland also mentioned that they first break bad news to the patient whereas in Pakistan, doctors break bad news to the people closest to the patient. This is due to the individualistic and collectivist family system of the two societies. Some of the laws in both countries were different. This can influence professional decisions of doctors, for example abortion. In Scotland, abortion is allowed by law however, it is prohibited in Pakistan. The respondents from Pakistan also mentioned that they were not very clear about the medico legal framework in the country as compared to Scotland. This again was attributed to the clearer and strong healthcare and legal system in Scotland as compared to Pakistan.

Chapter 6

Discussion

Chapter 6: Discussion

Key points

- This study shows that medical professionals adopt different models of professionalism in their daily routines.
- The study introduces the concept of 'process or activity of professionalism' which includes conflicts, dilemmas, self-regulation, and professional appearance.
- The professionalism of doctors is influenced by their external environment such as the healthcare system, the organizations, the regulatory bodies, and the public.
- The cultural differences between the two countries are reflected in the healthcare systems.
- Within countries and medical schools, variations are mainly due to different working environments and the ethos of the institutes and departments.

Introduction

Although professionalism is dynamic and contextual (10), this study found similarities in its understanding across Scotland and Pakistan. Many overlapping aspects of professionalism were mentioned by students and faculty from both countries. Table 29 shows a summary of different areas of professionalism, which will provide guidance throughout the discussion chapter.

Table 29: A summary of different areas of professionalism, mentioned by the study respondents, across both countries.

Professionalism Dimensions	Further exploration
Stakeholders	• Patients • Institutions, organizations, regulators • Public • Family • Politicians • Media • Healthcare system
Domains	• Knowledge • Skills • Behaviours • Attitudes • Practices
Level/Approach	• Superficial • Strategic • Deep
Range	• Attribute • Behaviour • Attitude • Value • Belief
Research	• Positivist (e.g. assessments) • Post-positivist (e.g. surveys, quantitative case studies) • Constructivist (e.g. grounded theory, qualitative case studies) • Postmodernist (e.g. critical theory research, action research) • System based approach (e.g. complex adaptive system, complexity theories)

A thematic analysis of the data revealed some general and specific themes, with respect to the title research question, 'How do medical students and clinical faculty members from two different cultures perceive professionalism'? All these themes discuss the similarities and differences between Scotland and Pakistan. The first section of the discussion chapter will explain the general findings which were derived from the interaction of different themes. These findings are discussed as:

1. Models of professionalism
2. Process of professionalism

The second section explains the individual themes which came from the results. Every theme will be discussed considering the similarities and differences between the two countries. The themes discussed in the second section are as follows:

1. Influence of healthcare system on medical professionalism.
2. Curriculum, teaching and assessment of professionalism
3. Roles

4. Approach towards patients
5. Dealings with colleagues, teams, and other healthcare professionals
6. Self-regulation
7. Image of a doctor in society and family
8. Limitations, and conflicts

Section I: General observations from the interaction of different themes

The first section will explain findings from this study which was derived as a result of interaction of different themes. These specific findings are discussed as:

1. Models of professionalism
2. Process of professionalism

1. Models of professionalism

Professionalism cannot be presented in one single model for all the organizations. Every organization has its own understanding of professionalism, which forms the ethos of that organization. The ethos is formed by the collective perceptions of stakeholders of that organization. This study has identified the following four models of professionalism.

1.1. Dimension based model
1.2. Themes based model
1.3. Belief to attribute based model
1.4. Outcome-based model

1.1. Dimension Based Model

The analysis of data from one of the Scottish medical schools (Case 3) suggested the multi-dimensional nature of professionalism, shown in Figure 29.

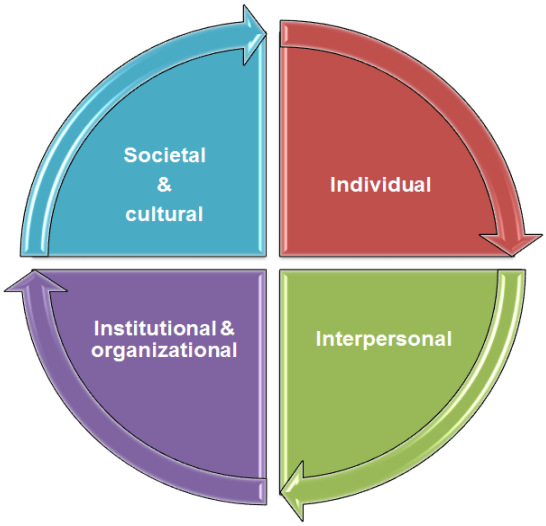


Figure 29: The model of professionalism for Case 3.
The model is based on combined results from faculty interviews and students' focus group. It shows a multi-dimensional approach.

A similar model was suggested in the literature for assessment of professionalism (23). The individual domain includes attributes such as altruism, empathy, responsibility, honesty and reflection. The interpersonal domain included attributes for leadership, mentoring, team working and dealing with colleagues. The organizational factors included institutional ethos, teaching and learning environment, value for research, organizational size, and openness to change. The cultural factors which had their role in influencing professionalism include societal norms and standards, expectations of society from doctors and medical students, religious influences, and economic conditions.

1.2. Themes Based Model

The fourth medical school from Khyber Pakhtunkhwa (KP) province, Pakistan followed the thematic model of professionalism. A model of professionalism was made for this medical school, using a belief-to-attribute scheme (Figure 12 on page 98). The four pillars of ethics: to respect the autonomy of a patient, confidentiality, justice and non-beneficence form the core for a professional doctor. The approach towards the patient, keeping in view the norms of society and beliefs of the patient will form a professional doctor, and he will be acceptable and adjustable to any system or any culture. A representative statement by a Pakistani doctor from Case 4 for 'ethics as core for professionalism' is given below.

> "A patient is a human being who is ill and in pain. This person is representing a society. He has some responsibilities; for those who are affected due to his illness. So we have to deal him in the best manner. That's where the universal four pillars of ethics come in. Those four pillars should be rooted deep in a doctor, that is, he should be able to respect the autonomy of a patient, confidentiality, justice and non-beneficence. So this is my definition of, or understanding of a professional doctor." (IK FP3 C4)

The model for a professional doctor, based on ethics and belief system is shown in Figure 30. Professionalism, according to this model can be defined as, an ethical approach towards a patient, keeping in view the norms of society, and beliefs of a patient.

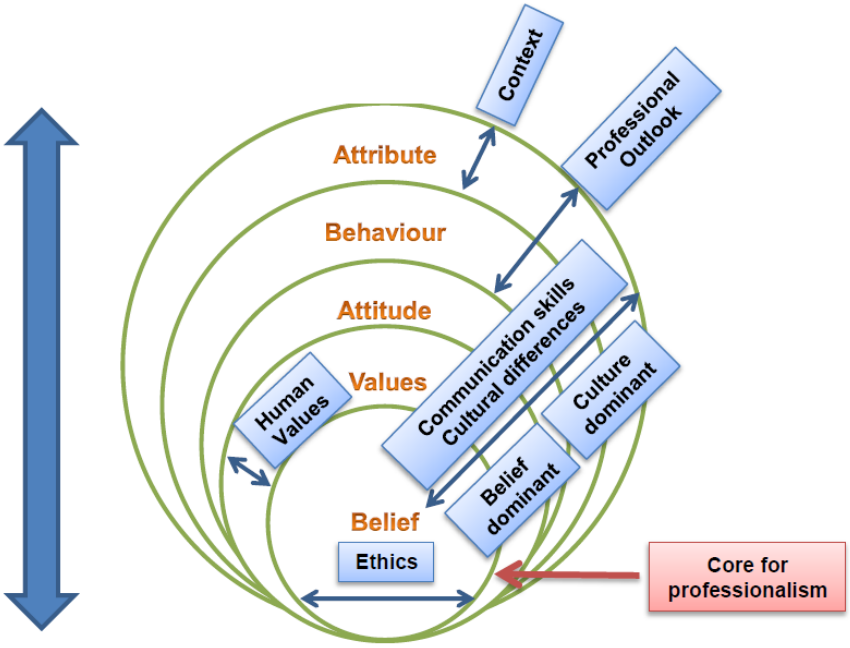


Figure 30: Belief-to-Attribute scheme and its relationship to themes of professionalism for Case 4.
The arrows show the guidance and relationship of one level to another and the domains covered by specific criteria for professionalism.

However, the definition based on this model does not specifically mention about the guidelines by regulators or organizations. Moreover, some of the important areas, mentioned earlier, such as keeping up-to-date, uncertainty, conflicts, and self-regulation are also not mentioned in this definition. Some models in the literature also advocate for an approach based on addressing different areas of professionalism, such as uncertainty, knowledge, values, self-image, learning from experience, and methods of professional development (208).This shows how the definition varies from one institute to another institute, which does not mean that one institutional definition is better than another. However, the institutional definition should include the use of guidelines as a part of professionalism.

1.3. Belief to Attribute Based Model (Spiritual or Religious Model or Self-exploration Model)

This model of professionalism is based on the level of professionalism, whether professionalism is at superficial level or deep level. The fifth medical school from Khyber Pakhtunkhwa (KP) province, Pakistan followed this model. This private medical school has strong Islamic religious values, and the main form of teachings of professionalism is through the informal curriculum. The medical school has also introduced its own book, based on Islamic values for a professional doctor (44). A representative statement by a Pakistani doctor from Case 5 for a 'strong belief system for professionalism' is given below.

> "Knowledge and evidence are the two factors which are good in modulating a person's attitude but these are not enough to change the attitude of that person. So faith, my internal believes, my thoughts, they are more important to regulate me, and we should work on this. When I say faith, I don't mean Emaan (belief) and Islam. I mean faith of anybody. What is there in the mind, it has to be combined with the conviction from the heart, and when mind and heart combine together, only then you will see the attitude change, otherwise you will not. Hence, the most important is the faith of a person, what he believes in. When I say faith, I mean he does not believe it from his mind only, but he believes it from his heart as well, and it is the intrinsic regulation which is more important than the extrinsic regulation." (NUH FP6 C5)

Figure 31 shows the visual model of professionalism for this specific medical school.

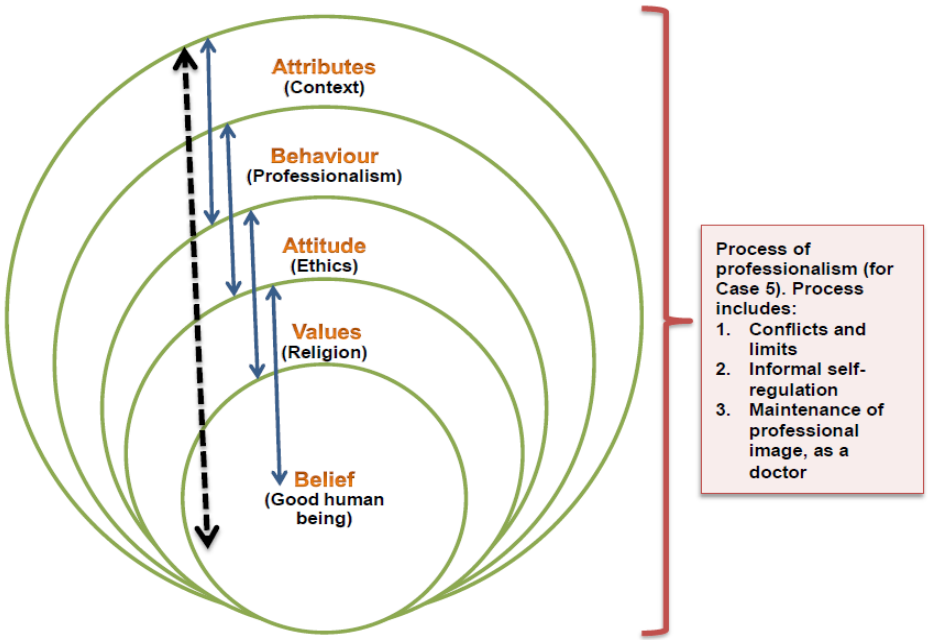


Figure 31: Belief-to-Attribute scheme and its relationship to professionalism for Case 5. The model reflects professionalism in a private medical school with strong religious values. The arrows show the guidance and relationship of one domain to another and the domains covered by specific criteria for professionalism.

The model depends on the level of professionalism. One of the study respondent said that, at the superficial level, a doctor may be just responding to the context, and his response may appear artificial. However, a deep professional will have a genuine empathetic attitude towards his/her patient, and the response will be strongly grounded in his/her belief system. The models which are used in clinical practice to improve such an approach are the reflective practitioner, inner apprentice, inner consultation, and mindful practice (47-49, 209). The model can also be explored with application of the Johari Window to understand 'unknown' and 'blind' self (121).

1.4. Outcome-Based or Role Based Model

The outcome-based model for professionalism has been introduced by the GMC and Scottish Deans' Medical Curriculum Group (25, 26). The sixth medical school, from Rawalpindi city, Pakistan follows the outcome-based model. However, it mainly teaches professionalism through the informal curriculum. The collective analysis of interviews and focus groups formulated the institutional model which closely resemble the Tomorrows Doctors model (26), but encompassed by contract with society, a concept by Cruess *et al* in their papers on professionalism (31, 95). A representative statement by a Pakistani doctor from Case 6 for 'different roles of a doctor' is given below.

> "In the context of a doctor, I think professionalism means certain competencies that a doctor should have. We can divide those competencies in broader areas for example, as a scholar, as a doctor, and administrative capabilities." (FM FP2 C6)

An illustration in Figure 32 shows the visual model of professionalism for this specific medical school. This model can also be called as the 'role based model' because different outcomes are arranged around the three important roles of a doctor. In this case, professionalism depends on the given role of a doctor at a specific time, keeping in view his contract with society.

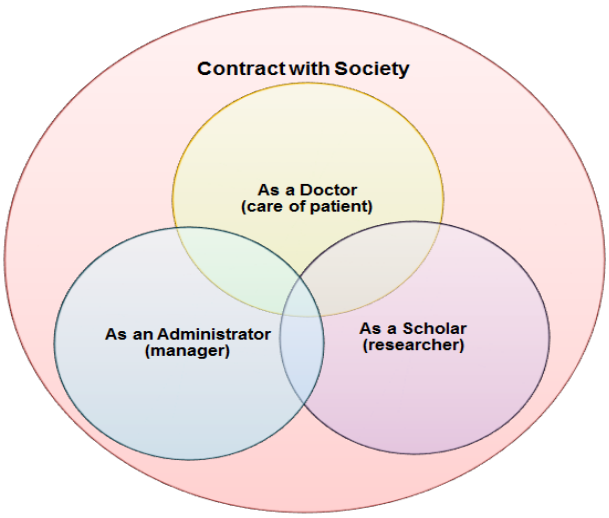


Figure 32: The model of professionalism for Case 6.
The model is based on combined results from faculty interviews and students' focus group. It shows three main roles of a professional doctor, all being covered by a contract with society.

2. Process of professionalism

The 'process of professionalism' is formed by three main themes, which came from the data; conflicts, self-regulation and attributes of a professional doctor. After some careful analysis, the themes were presented in a three circle model or as a tree, shown in Figures 33 & 34. In the three circle model or in the tree, the conflicts are the inner most circles or the roots of the tree. These include all the external and internal conflicts and limitations, where the internal conflicts are not visible to the outer world, and are hidden under the ground, or in the inner circle. The conflicts may be either related to balance between the roles, resources, justice or dilemmas.

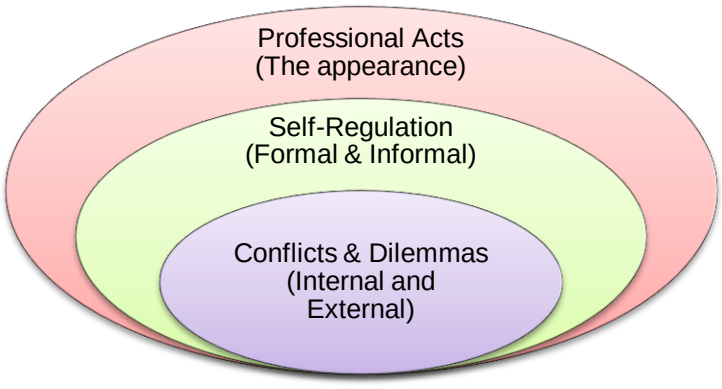


Figure 33: The process of professionalism.
Professionalism is the management of conflicts and dilemmas through self-regulation and guidance.

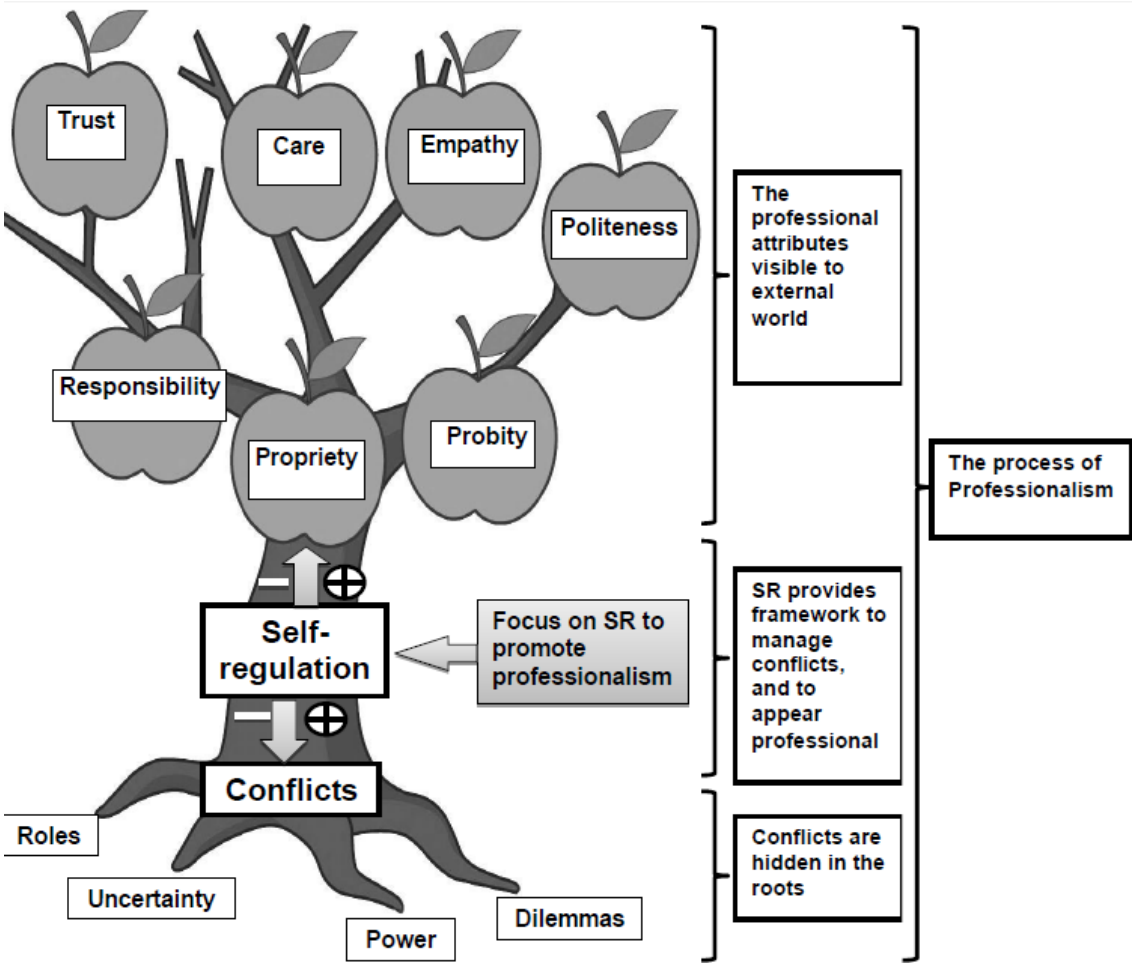


Figure 34: A tree metaphor to show the 'process of professionalism' including the themes of conflicts, self-regulation, and attributes of professionalism. The roots are formed by conflicts, the trunk by self-regulation, and the fruits by attributes of professionalism. (SR = Self-regulation)

The middle circle or the trunk of the tree forms self-regulation. A robust self-regulation is as necessary for professionalism, as a thick trunk is required for a strong tree. This is the most important or crucial part for professionalism, as it provides a framework for conflict resolution and how to appear, act and behave professionally. The data suggests that self-regulation is a multi-faceted concept, and can be divided into types, levels, situations, and limitations. In the types, it can be formal as in appraisal or revalidation, or informal in the form of reflection on practices, mentor-mentee meetings, and attending conferences. It can be practiced at either the superficial or the deep level, where the superficial level self-regulation will reflect weak professionalism while the deep level of self-regulation will mirror deep professionalism. The situation for self-regulation can be within hospital with teams, colleagues or students, and outside hospital while being with family or in the community. The limitations include the collection

of evidence, lack of training, system failure, and pressures from the family, peers and community. The better self-regulation is, the better a person will manage conflicts, and the more professional s/he will appear, act and behave.

The outer circle or the leaves and fruits on the tree show the exterior of doctors or medical students such as their professional outlook and communication. It is the appearance of a doctor to the external world. This includes the external attributes of professionalism of doctors for example care, responsibility, politeness, empathy, and showing respect. The stronger a person can regulate his conflicts, the better professional he will appear in front of patients, colleagues and society.

I have called the combination of these three themes as 'the process (or tree) of professionalism'. Following this model, I have defined professionalism as, the management of limitations, conflicts and dilemmas through self-regulation, and guidance. A model in the literature presents conflicts, with context and resolution, however, the focus of the model is on 'conflicts' only (10). The model in my study shows the link of themes of conflicts, self-regulation and 'professional attributes', thus providing a more detailed understanding of professionalism.

This model shows the importance of self-regulation to become a professional doctor. It leads to a disciplined approach, and hides doctors' conflicts, and people can only appreciate the fruits. The down side to this model is that strong self-regulation is necessary for professionalism but there is a danger that it may lead to depletion of the motivation stores (14, 210). The depletion of motivation stores can negatively affect professionalism (or the discipline), and can lead to dishonesty (210). One proposed suggestion from the data is to step back or leave the job for a while, to restore the motivation to self-regulate, and to become honest with the job and towards patients. Another suggestion by a study respondent was to find a mentor who can guide and provide support through external regulation so that the job does not become exhausting.

The focus on self-regulation for professionalism shows that its limitations need to be addressed, to improve the doctors' and medical students' self-regulation. Therefore, it is necessary to explicitly train them in self-regulation, so as to become better professional doctors.

Section II: Themes for professionalism in the cultural context

The second section explains the individual themes which came from the results. The first theme for 'healthcare system' is discussed through the lens of CHAT, to show how theoretical perspective can enhance our understanding of the topic. The themes discussed in the second section are as follows.

1. Influence of healthcare system on medical professionalism
2. Curriculum, teaching and assessment of professionalism
3. Roles
4. Approach towards patients
5. Dealings with colleagues, teams, and other healthcare professionals
6. Self-regulation
7. Image of a doctor in society and family
8. Limitations, and conflicts

1. Influence of the healthcare system on medical professionalism

The healthcare system of a country reflects the national culture and practices of medical professionalism. One of the key reasons for professionalism to appear 'dynamic' in both the countries is due to the dynamic nature of the healthcare system, following the Complex adaptive system (CAS) model (18). The data suggests that professionalism, in general, is imposed by the healthcare system. Hence, the term 'system-centred approach' towards patients is more commonly practiced than the 'patient-centred approach' recommended by the regulatory bodies. It needs to be noted that a regulatory body itself is just a part of the bigger healthcare system. The analysis of data suggests that the regulatory bodies and doctors try to protect patient rights by attempting to provide 'patient-centred care' against the system which demands for a 'system-centred care'. However, at times, the situation is such that doctors have to opt for the 'system-centred approach'. A better term may be a 'context-centred approach', which incorporates both system-centred and patient-centred approaches. It can be defined as, the approach of a doctor towards a patient in a given context. This debate of a system-

centred approach is not just limited to this study but it has also been reported in recent literature (83, 211). The literature devise methods for doctors to act professionally despite system constraints, such as explicit assessment of professionalism as a competency, developing an organizational culture of professionalism, and adhering to the principles of ethics and morality (83, 211).

In Pakistan, the lack of service structure for doctors was mentioned as one of the biggest weaknesses of the healthcare system. This adversely influences the career of doctors. A dispute between junior doctors and the government resulted in a confrontation. The media presented a negative image of doctors, describing them as self-centred and blamed them for patients' mortality (212-215). The doctors were aware of the ethical and professionalism issues associated with the strike but felt that the healthcare system was not functioning optimally, to provide care to the patients (216). A representative statement by a Pakistani student for the role of service structure is as follow.

> "The problem here is that we don't have service structure for doctors. A doctor has to look after his family. If he talks about his pay, people say that he is selfish and only cares about his pay, and does not care about the humanity and the people who are dying. In our setup, people consider them as Messiah or angel. They take them as machines whose only job is to save humanity. They do not consider his personal life and responsibilities towards his family. This factor has aggravated the problem." (FGD S C6)

Another difference between two healthcare systems is based on divide between private and public sectors. In Scotland, there are no private medical schools but, in Pakistan, there are 51 private and 38 public medical schools, a total of 89 medical schools (217). I collected data from two private and one public medical school, almost a 2:1 ratio, roughly based on the number of private and public sector medical schools. Most of the discussion is based on data from Pakistan, and how privatization is affecting the culture of professionalism in Pakistan. However, the discussion can also be useful for Scotland for future planning because privatization and commercialization of healthcare is inevitable due to immense cost of healthcare.

The commercialization and privatization of healthcare has challenged the historical model of medicine as a 'calling' (98). There are mixed views in Pakistani medical society. Even some doctors working in the private institutes are against their business philosophy. Medicine was always considered as a vocation in Pakistan but

the private health sector has brought in the element of monetary gain and power. The study respondents said that, although there was an element of 'power' in medicine, as it gives control over a patient's body, the money factor has brought in the element of financial power. Thus, those who can afford can send their children to private medical schools. This has seriously affected the merit in the country and questions are raised about the competency of doctors graduating from these private medical schools (218).

The ratio of almost two private medical schools to every public medical school has also affected the balance in the Pakistan Medical & Dental Council (217). All the Principals of the medical schools are, by default, members of the PMDC. Due to an imbalance in the presentation of private versus public sector, mostly, decisions are taken in favour of the privatized forces which has critically affected the reputation of the regulator on national level (219, 220). The public and the doctors' community now observe the regulatory body as voice of the private sector.

Moreover, beside private medical schools, there is also a culture of private clinics in the evening time. Some of the doctors working in private practice spent a share of their money in running charities however, they do not project it. The society is now developing a negative image of doctors due to private practice because the purpose is monetary gains, and not to serve patients out of hospital timings. The private clinics and hospitals are providing almost two third of the healthcare to the population of the country, and so a small number of unprofessional cases can have a bigger impact on image of a doctor.

However, private medical schools also have a positive impact on medical education in the country. They have played their role in introducing innovations in medical education such as introduction of problem based curricula, integrated curricula and hybrid curricular models in Pakistan (221, 222). The study respondents said that private medical schools have created an atmosphere of competition for the public sector medical schools that were accustomed to old pedagogical style and were not accepting the changes in the curriculum and assessment techniques. The private sector has been able to attract high quality faculty members in their respective fields, who have brought innovations at their departmental level. They have

expanded the culture of scholarship, and have motivated students to actively participate in research activities (218, 223).

Some private sector medical schools have established collaborative projects with international medical schools and universities, which has helped to improve the understanding of medical education (224). I observed from this study that the activities in the UK healthcare sector have positively influenced the medical practices in Pakistan. From the perspective of CHAT, these are seen as two different activity systems, which are porous and influence each other as a wider community of healthcare professionals.

The pharmaceutical industry has also influenced the professionalism of doctors by giving them personal and professional incentives to prescribe medicines to the patients. In the UK, where the state controls the drugs, this effect was not raised by study participants. However, in Pakistan, the pharma industry is influential and only some clinicians have managed to avoid it. Most doctors prescribe medicine of the company which provide incentives to them. Generally, it is not possible to avoid incentives of the pharma industry but some doctors deal with it professionally while others get into the trap of commercialization and personal gains. The professional doctors, usually ask for incentives to improve patient care for example, asking for a cooling system or a dialysis machine, which is required for patients but the government hospitals cannot afford it. The same practice was observed in two private teaching hospitals, affiliated to the private medical school (Case 5), where the clinicians asked for incentives to improve the patient care, and in return, they prescribed the medicine of the specific pharma company.

The doctors consider these dealings as a professional practice because the aim is not a personal gain but to improve the quality of patient care which is the States' responsibility, but cannot be provided due to limited resources. Such public-private partnership is encouraged by health economists but need some precautionary measures such as to look for their efficiency, risk, complexity, accountability, and governance; so as to handle them in a professional manner (225). The study respondents from Pakistan said that unprofessional way of receiving incentives is in the form of personal gains such as holiday trips and luxury tools for home. This form of unprofessional practice has also been reported in other countries such as

the US, China, and Germany (102, 103, 226). This theme is further explained through the lens of CHAT.

1.1. Understanding the influence of healthcare system on medical professionalism through the lens of Cultural Historical Activity Theory

Cultural Historical Activity Theory helps in understanding the dynamics of the healthcare system (1). The study facilitated an understanding of the bigger role of the healthcare system, and how it affects professionalism at an individual level. The activity diagram for the role of the healthcare system is illustrated in Figure 35. The figure shows how the expression of professionalism is influenced by the subjects, tools, rules, community, division of labour, and objectives. In this study, all the themes for professionalism were influenced by the healthcare system.

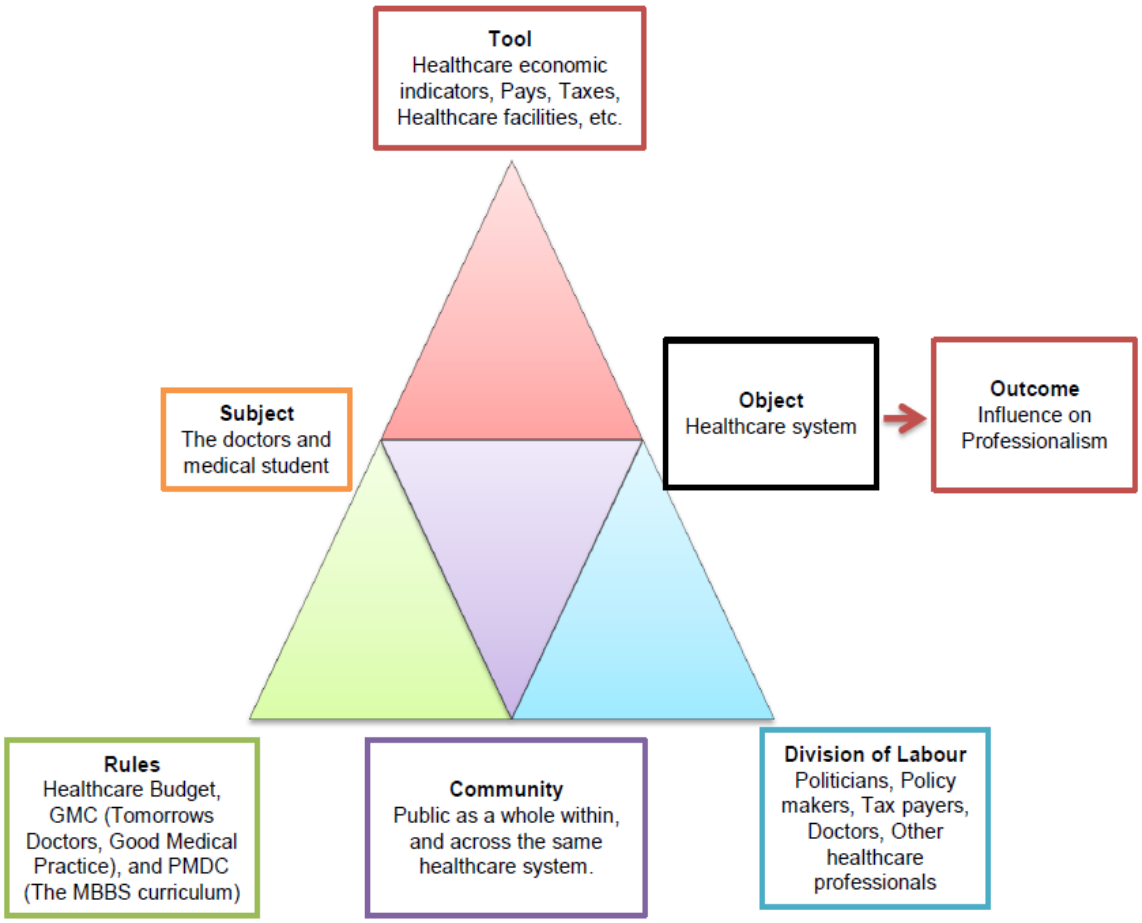


Figure 35: An example of the activity system for the influence of healthcare system on professionalism of doctors and medical students.
Tools, rules, community, division of labour, subjects, object, and outcome changes with different country or institution. Redrawn, with modification, from Engeström (1).

The expression of professionalism is dependent on how a doctor works in a specific healthcare system. It is influenced by the culture, history, knowledge, skills, ethics, practices within local norms, working conditions, and religious values. Moreover, the activity system of one country also affects the activity system of another country. For example, some doctors from Pakistan mentioned that they use the GMC's documents 'Good Medical Practice' and 'Tomorrows Doctors' for guidance to practice in Pakistan. At this point, it may be appreciated that the documents have been written in such a format, that they can be generalized to healthcare systems of some other countries.

This study found that the subjects (study participants), who switch from one activity system to another activity system, adapt to the second activity system. However, they still have a cultural and historical background of their first activity system, which they follow as a guiding philosophy for themselves. This suggests that, whilst there are variations, the system is basically universal. The example is of the two Pakistani doctors who graduated from Pakistan but joined the NHS and have worked in Scotland for more than eight years. They both mentioned that the activity system of Scotland is more standardized and offer more services. Due to more facilities, they can perform more professionally in the UK than in Pakistan. However, their beliefs have not been affected; rather they have helped them in some areas, such as in 'the care for elderly patients'. In Pakistan, elderly people are cared and respected more as it is a collectivist society compared to Scotland which is more individualistic (20). The care of elderly people has its roots embedded in the family structures in Asian cultures as compared to the Western culture (19). The Pakistani doctors mentioned that elderly patients in Scotland liked their company more as compared to their other fellow doctors. However, as this is a personal opinion based on a personal encounter, it cannot be generalized to everyone. An example of a representative statement by a Pakistani doctor working in Scotland for 'care of elderly' is given below.

> "There are a lot of cultural factors that interfere such as, the way you have been brought up, and trained. In general, human beings have similar conscious, for example, bad things will include lying, not looking after ill person, not thinking about humanity, and not looking after elderly people. So these are conscious things which I think have been emphasised in our culture. In the same way, it has also been emphasised in our religion. I remember when I first came to this country (Scotland); I was looking after elderly patients for a few days. I went so well with them that one of the patient's daughter came to me, and said that, 'there is a lot of cultural element to the way you are looking

> after my mother, because she was in hospital before as well. She was looked after very well but the way you are looking after is different'. So, I think, there are some cultural elements, which will make you a good professional doctor." (MFK FP2 C2)

The analysis of the data showed that society (community in terms of CHAT) in Pakistan has the same expectations from doctors and medical students as in Scotland such as respect, courtesy, and approachability. Both societies have a conservative view about doctors, and expects them to follow the historical model of 'calling', instead of the 'career' (98). This indicates that despite few cultural differences on the appearance, there is a core expectation from a doctor across both cultures. These expectations can provide guidelines to build a curriculum for professionalism to enable doctors to work across different cultures. The training in professionalism can equip doctors to handle different types of cultural situations.

In Scotland, the healthcare system, GMC, and Scottish Deans' Medical Curriculum Group (SDMCG) have standardized medical education (rules in terms of CHAT). Consequently, there was not much variation in the perceptions of the faculty members and students across cases. Their understanding of professionalism was similar to their equivalents in Pakistan, and they recognized that professionalism does not mean perfection. In Pakistan, despite the weak regulator, perceptions about professionalism were aligned by religious beliefs. However, the perceptions were more idealistic following the religious model. In practice, there were extreme variations from unprofessional to extremely altruistic approaches. In Pakistan, the professional and altruistic approaches are cherished, but unprofessionalism flags a danger to the integrity of the medical profession and demands external regulation.

In Scotland, doctors avoid treating their family members and this practice is routinely followed. The reasons for this are the standardized healthcare system, strong primary care, and referral system. In Pakistan, although doctors prefer not to treat family members, it is difficult for them to avoid doing so because the healthcare system is poorly structured. Consequently, without proper support of primary care or GPs in Pakistan, a culture has developed, where people either go directly to tertiary care hospitals or to the private hospitals. An example of a representative statement by a Pakistani doctor (Case 4) for treating family member is as follows.

> "One of our relatives came to me for treatment with very advanced stage breast cancer with liver metastasis and the outcome and outlook was not very good. I tried to refer that relative to another oncologist for treatment but they refused and thought that I was trying to avoid them. I explained why I was doing that; they just couldn't realize. So I had to take that patient. So, this is the problem which comes in cultural context that for good medical practice, as far as the UK is concerned, you shouldn't be treating your near and dear friends or family members but when it comes to Pakistan; being a family member, it is expected of you that you should be treating them, as a matter of their moral right on you." (AJ FP2 C4)

The literature suggests the influence of national politics on professionalism of doctors (101). 'Professionalism movement' was introduced by politicians, in 1972, in an attempt to break the homogeneity of the profession, and its apparent alliance to the Conservative Party (101). The heterogeneous patterns of results were latter shown in the polls, which disclosed how professionals may be manipulated by the politicians (101). This illustrates how historical and political influences may change the nature of professionalism when viewed from the theoretical perspective of Cultural Historical Activity Theory.

The national politics and interest in escalating the professionalism debate has not affected the approach of doctors towards patients. However, it certainly has raised their concerns about their own practices. It has proved to be an important milestone towards the improvement in the quality of healthcare. The professionalism movement also made doctors think more explicitly about their behaviours, attitudes and broader role in society. This has led to an increase in social accountability, social responsibility, and mindful practice (47, 227-229).

2. Curriculum, teaching, and assessment of professionalism

The study respondents from Scotland were not as explicit in considering 'ethics' as core for professionalism as they were in Pakistan. The reason is that in Scotland, ethics is considered as a separate subject from professionalism because of the advanced understanding of both topics. However, in Pakistan, professionalism is still a new concept and considered as a component of ethics. The data shows that the gap between formal and informal curriculum was greater in Pakistan than it was in Scotland. The consequence being that students in Pakistan learn that praxis contradicts with ideal practice.

Role modelling is one of the most important methods for teaching professionalism through informal and hidden curricula (11). The formal methods may include lectures, teaching through peers, role plays, simulation, and video (5, 230, 231). The explicit teaching of professionalism has its role but professionalism is mainly learned through the implicit teaching and role modelling (230). The data suggests that the undergraduate and postgraduate divide provides another distinction in the way professionalism is taught. It is explicitly taught through the formal curriculum to the undergraduate students, whereas the postgraduate students mainly learn it through the informal and hidden curriculum.

The study respondents expressed a concern that issues related to standardization of the assessors created confusion about standards of assessment of professionalism. Different assessors have different approaches for a similar clinical situation according to their experiences, which makes it difficult for the students to demonstrate the best practice. Moreover, the artificial context of the examination, for example, an OSCE station may be valid, but is not authentic. However, the constructive feedback by assessors is considered helpful by the students during the formative assessment sessions. Representative statements for assessment of professionalism by a Scottish doctor and a student (Case 1) are given below.

> "Simulated observation in exam situation is not the true reflector of professionalism" (PC FP4 C1)

> "Assessing communication skills in snapshot (station) is not true reflection of the communication skills. However, positive feedback is helpful in assessment" (FGD Student C1)

The data revealed that understanding professionalism is still at an early stage. The assessment instruments have not yet accomplished the capacity to cover all of its domains and areas, even with the use of multiple assessment instruments (134). This is because of the contextual nature of the topic where standards, which may be acceptable to one society, may not be to another. However, the data analysis suggested that despite these complexities, there are some attributes of professionalism which give students a framework to help them in their professional lives. These include probity, trust, respect, politeness, honesty, time management, altruism, attendance, and helping colleagues.

The theme for curriculum is further explained under the following sub-themes.

2.1. Promotion of good or professional doctors
2.2. Professionalism as a competency
2.3. Professionalism as a capability

2.1. Promotion of good or professional doctors

In both countries, almost all interviewers thought of a professional doctor as a good doctor (32). This indicates an overlap between good and professional doctors. The question that arises is, if the general public also think that a professional doctor is a good doctor, then why distinguish between good doctors and professional doctors? One of the difficulties is with teaching and assessment for 'the good doctor'. 'Goodness' cannot be assessed with present assessment instruments (66). It is also difficult to teach goodness because from a philosophical point of view, a 'good' doctor should be the teacher, so that students can also see the active role model. The question here is how to find a good doctor who can also teach how to become a good doctor. 'Goodness' is intrinsic to an individual and within the five years of a medical school, the students are still exposed to the external world for two third of their time per day, which influences their intrinsic motives (66). The data suggests that pressures from economy and social system play a stronger and more powerful role than the medical school curriculum.

The data suggests that whilst the concept of a good doctor and a professional doctor are congruent, they are not identical. Another way of looking at this concept is that, a deep-professional doctor can be considered as a 'good doctor', whereas a superficial-professional doctor can be considered merely as a 'professional doctor' (93). Both these explanations can be understood by the Belief-to-Attribute Model, explained earlier (Figure 31 on page 181). In that model, the inner circle forms the deep-professionalism or goodness in a person, that cannot be easily measured (as these can be masked by behaviours) while the outer circles form professional attributes, that can be seen and measured (66). The issue here is how to judge, who is a superficial-professional and who is a deep-professional? The judgement in such case is subjective, and varies from one person to another, and hence cannot be standardized. One way suggested by a study

participant from Pakistan (Case 5) was to collect multiple views and consider the dominant view as a correct view, but it lacks reliability and consistency.

Professionalism also means recognising and maintaining relationships within defined socially acceptable limits. One study respondent from Pakistan (Case 5) said that moderation of some behaviours differentiate a professional doctor from a good doctor, such as in case of altruism, where the doctor draws a boundary for self-protection. The moderation here is necessary, so as not to harm oneself while treating a patient such as, risk of exposure in treatment (232). Recent definitions of professionalism use the word 'fiduciary' instead of altruism (233). The difference between the two is that altruism means a complete range from service provision to selflessness. However, fiduciary includes only service provision, thus protecting doctors from heroic acts of selflessness to endanger themselves for their patients.

This study analysed the issue at a basic level but the similarities and differences between a 'good doctor' and a 'professional doctor' should be further explored in future research. Another question which might be explored is; 'does it matter whether a person is professional or good?' An illustration in Figure 36 shows some differences between a good, and a professional doctor.

Figure 36: Differences between a good and a professional doctor.
The inner circle on the left shows that goodness is intrinsic and the outer circle shows that professionalism is extrinsic.

2.2. Professionalism as a competency

Professionalism is considered as a competency by some of the regulatory bodies such as CanMEDS and ACGME (29, 234). In this study, some clinicians mentioned it as a competency but most students were of the view that the experience is more influential in developing professionalism. A 2×2 table in Figure 37 shows a 'conscious competence learning matrix'. The senior clinician with more exposure and those who also strive to achieve excellence, finally reach to stage of 'unconscious competence'. Experienced clinicians from both countries mentioned that professionalism has become a habit, after having experience of more than 20-25 years. The formal curriculum may prepare students for stages 1, 2, 3 of the 'conscious competence learning matrix', but the informal curriculum has its role in all the four stages. This suggests that the concept of professionalism needs to be addressed at the level of both formal and informal curricula to prepare the students for lifelong learning of professionalism.

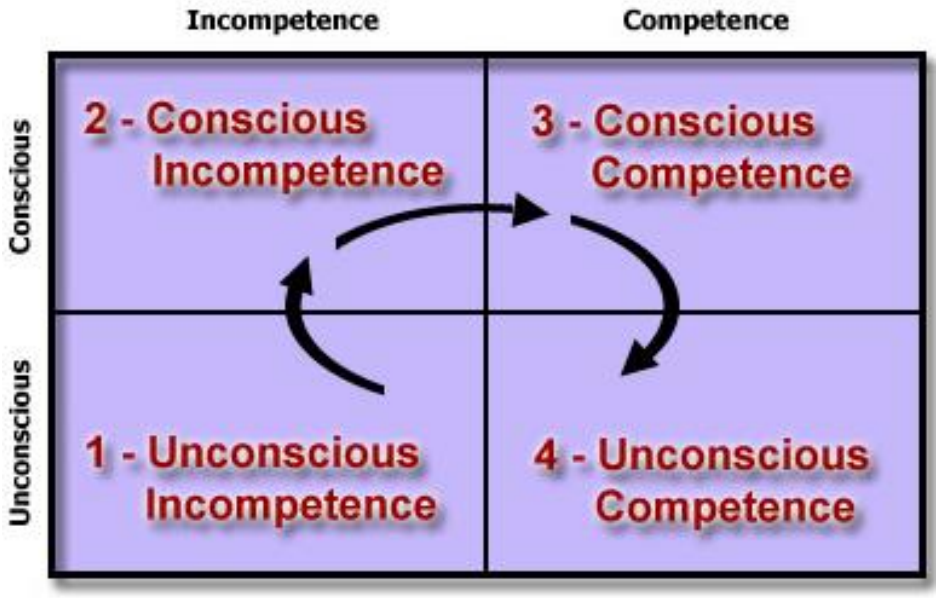


Figure 37: Conscious competence learning matrix for professionalism.

2.3. Professionalism as a capability (A move from competency to capability)

In this study, professionalism in different cultures was explored. The aim was to identify the reasoning behind cultural similarities and differences in understanding professionalism. After a detailed analysis of the data, I realised that professionalism may not be considered as a competency because it requires judgement for decision making. Some of its dimensions are beyond competency, also known as 'capability'. The concept of 'beyond competency' or 'capability' originated due to limitations of the 'competency framework' (235).

Competency has been defined in different ways by different people (236, 237). It is difficult to make proper standards for it because there are different levels from novice to expert (237, 238). A competency is reductionist in nature, limiting the views about the broader and multiple contexts, and impeding professional development (237, 239). The reductionist nature of a competency gives a false sense of simplification of a complex phenomenon, such as professionalism (128, 237, 240). The competency is criticised that it is tested in a controlled environment (236, 237, 241, 242). Moreover, it does not consider the complex situations and different contexts, which may arise in normal day-to-day activities (237, 241, 242). The present assessment instruments are unable to capture all situations and contexts because of issues with their validity, reliability and generalizability (237, 241, 242). This led to the concept of capability which has characteristics of competency and beyond. Capability is defined as:

> 'Capability has been described as a holistic attribute with capable people more likely to deal effectively with the turbulent environment in which they live (or work) by possessing an all-round capacity to manage continual change' (237, 243).

Capability has also been defined as:

> 'having justified confidence in your ability to take appropriate and effective action to formulate and solve problems in both familiar and unfamiliar settings' (237, 244).

A competency includes what the individuals know or are able to do in terms of knowledge, skills, attitude whereas a capability is the extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance (2). This suggests that a culturally sensitive curriculum for

professionalism may not only test the competence of students but also their capability because they adapt to changes according to different contexts. It is evident from this study and the literature that professionalism is 'context-specific', and varies from one situation to another. This suggests that professionalism is not a competency but a combination of many competencies or a 'meta-competency'. Capability or ‘beyond competency’ is also called as a meta-competency' (245). The contextual nature of professionalism involves judgement, innovation, and flexibility, which are key characteristics of a capability (2).

Assessment of capability for professionalism is difficult (129, 246). The question here is that if professionalism is considered as a capability, then how it can be assessed? The reason is that most of the assessment instruments for professionalism are based on 'assessment of competency', whereas the topic itself fits to a 'capability' framework. This suggests that the nature of the topic is so deep that even multiple assessment instruments may not be able to encompass all dimensions of professionalism (134). However, the modern assessment strategies and instruments such as, assessment for learning, reflective portfolios, enhanced feedback, narratives, work-place based assessments, and performance tests, can assess ‘capability’ if used appropriately (2, 129, 246). This may require application of the relative scales, not absolute scales because the decisions are made on human judgement (129). Another requirement is to establish inter-rater reliability to reduce bias because of human judgements (129). The economics, such as the cost in terms of time, and faculty development for a ‘capability curriculum for professionalism’ are additional constraints to introduce ‘professionalism as capability’ (129). Moreover, implementation of such ‘curriculum and assessment’ requires training in assessment of both the external and internal examiner (129). This requires collaboration between medical schools or universities, which will need resources and a move towards ‘capability’ at a national level (129). Table 30 shows some major attributes of capability.

Table 30: Attributes of capability.
Redrawn from Gardner *et al* (237).

- Knows how to learn (can make the right judgements)
- Works well with others
- Is creative (innovative)
- Has a high degree of self-efficacy (a belief that one is capable of performing in variety of situations)
- Applies competencies to both novel and familiar situations

The attributes of capability means to build new ideas with the background of competency for knowledge and skills (237). For example, knowing, how to bring innovation to competence, according to different situations and contexts (237). Professionalism at undergraduate level can be considered as a competency, but if the element of culture is added to it, then it becomes innovative because now, the students have to adapt according to the context, and switch from 'professionalism as competency' to 'professionalism as capability' (247). A capable professional doctor is more likely to be able to manage complex and non-linear challenges as compared to a competent doctor (237). Moreover, experience is another factor, which differentiates competency from capability. In competency, the experience is not explicitly mentioned as an attribute but capability recognizes the importance of experience (245).

'Capability' and 'professionalism' align with each other, and almost all the attributes of 'capability' are in congruence with 'professionalism'. Capability is considered as dynamic and complex as compared to competency. It appreciates varied contexts and regards the experience of the doctor, as an important factor. These characteristics are also common in professionalism (2, 245). Figure 38 shows the association of 'capability' and 'competence' in a complex adaptive system (2). It suggests how capability can be further employed in the context of 'professionalism'. 'Competence for professionalism' can be considered as a more pragmatic and cost-effective approach, whereas 'capability for professionalism' is a more idealistic but costly approach.

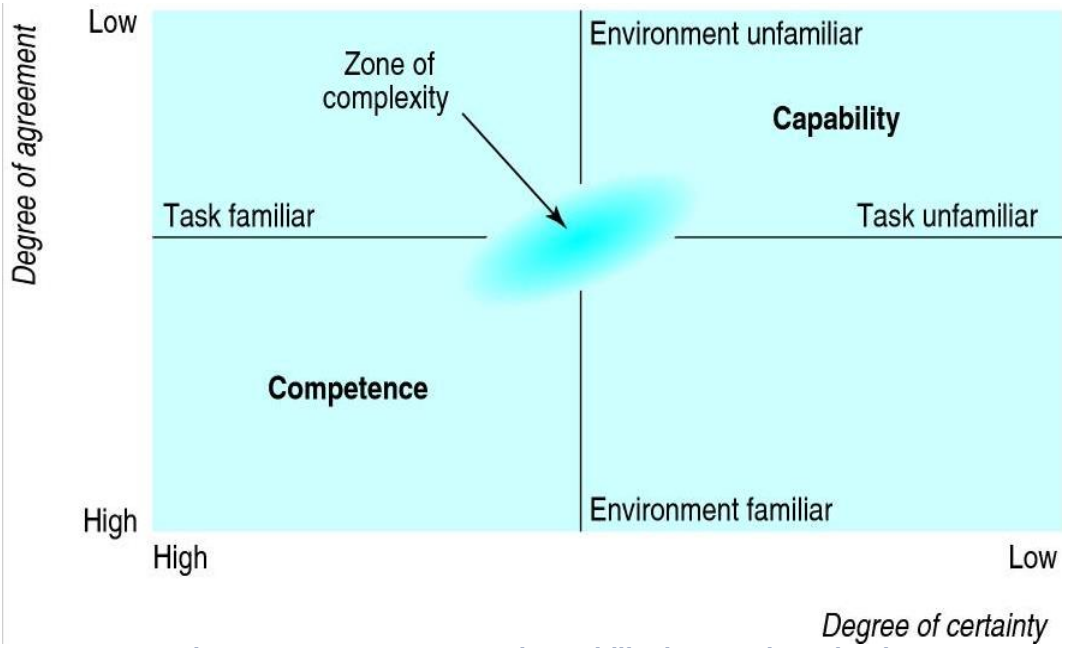


Figure 38: Competence and capability in complex adaptive systems. Validity and reliability for assessment of 'competence for professionalism' are easier to establish as compared to 'capability for professionalism', which has higher degree of uncertainty. Reproduced from Fraser *et al* (2).

The debate of considering professionalism either as competency or capability does not mean that one is better than another, but it shows that capability and its dimensions can be a useful model to develop a curriculum for professionalism (237). It is also to be noted that both competence and capability have their role in developing a student as a doctor. They both have similar relationship of 'internalization' and 'externalization' in a cyclical form, as in CHAT, where the students move from the novice to expert in a form of spiral cyclical ladder, initially starting with 'competency' and then moving to 'capability' (1). Capability provides a complementary set of attributes to competency and the combination of these attributes is central to the practice of professionalism (237). Figure 39 shows the relationship of competency and capability, and how they move up in a cyclical spiral form. The increasing levels show moving from a novice to an expert level. This concept of 'internalization', and 'externalization' in spiral form is also mentioned in the Cultural Historical Activity Theory (1). It explains that initially, the activities are external to a person but with repeated exposures or practices, the activity is internalized which leads to expansion and transformation in learning. Cultural Historical Activity Theory suggests that learning is not a one-time activity but expands with experience (1).

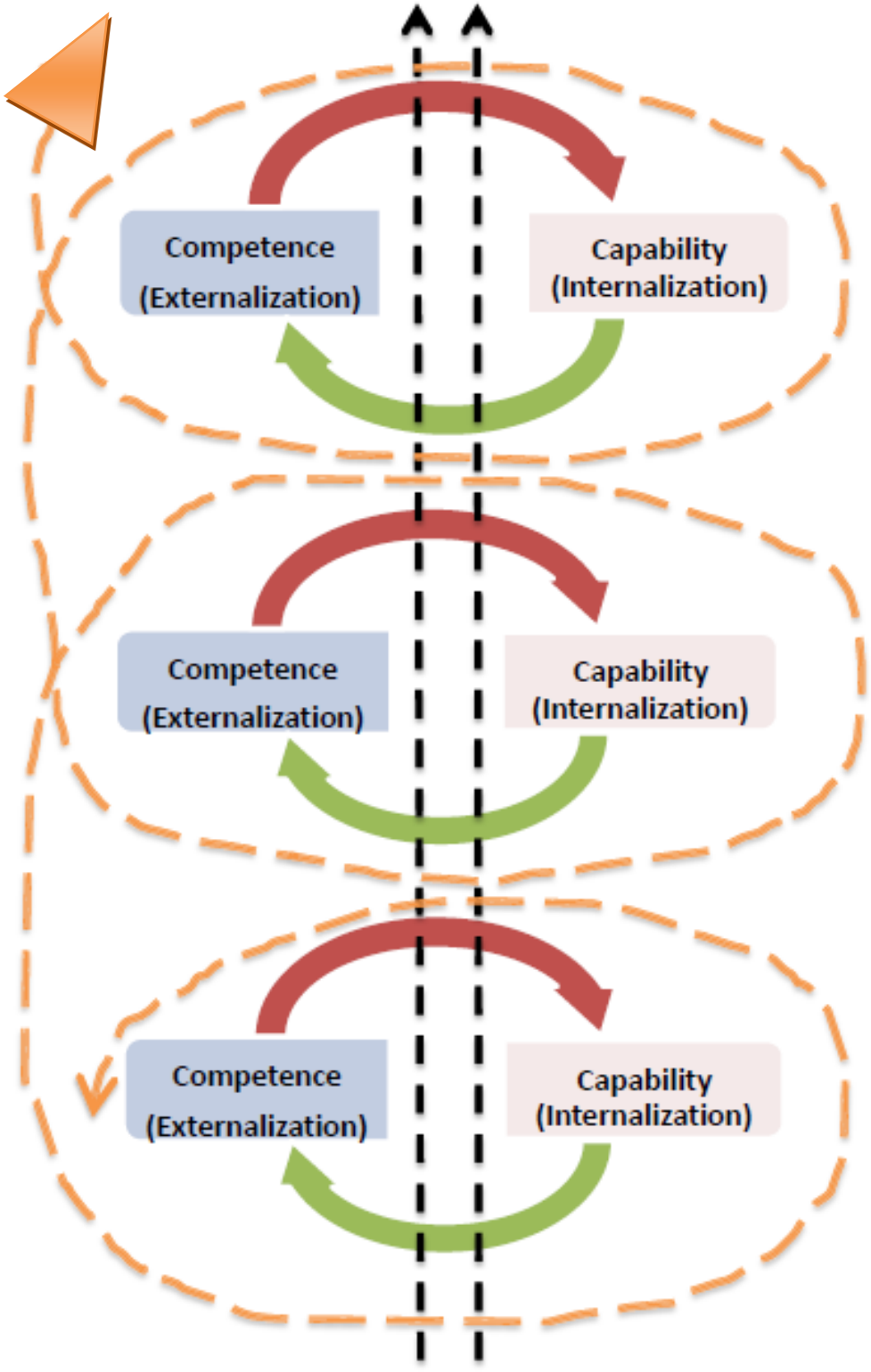


Figure 39: The relationship of competency to capability in a cyclical spiral form. The model follows the 'internalization', and 'externalization' concept of the Cultural Historical Activity Theory.

2.3.1. An example to differentiate 'competence' from 'capability'

One of the issues, discussed in this study, was the issue of general surgeons operating Caesarean sections in peripheral practices in Pakistan. The reason is the lack of availability of obstetricians in the peripheries. In this situation, the general surgeon is competent to perform Lower Segment Caesarean Sections (LSCS) but his/her capability is in question because s/he cannot make judgements about the indications for Caesarean sections. The Fellowship qualifications and the regulator, PMDC, do not specify or limit a surgeon to particular surgeries. However, the surgeons themselves are aware that, although the system recognizes them as competent, they know whether they are capable for any particular surgical technique or not.

A similar issue was raised by another surgeon where he showed his concern about the private practices of fellow surgeons, who have 2-3 years' experience Post-Fellowship. However, they are still not capable of performing certain complex surgical techniques such as Whipple's procedure (a major surgical operation involving the pancreas, duodenum, and other organs). This operation is performed to treat cancerous tumours of the pancreas, and multiple anastomoses are made. The surgeon was of the view that young surgeons with Fellowship, but less experience, should not be allowed to carry out complicated surgical techniques.

These examples show the importance of considering professionalism, not as competency but as capability, to make appropriate professional judgements in real life complex situations, depending on the context and looking at ones' own experience. However, the difficulty still remains with the complexity of the 'capability curriculum', which needs capable curriculum planners to work with a capable team, alongside capable professional doctors. Furthermore, the issues with 'assessment of, or, for capability', and resources required for faculty development puts additional strain on the already over-burdened healthcare system and academia, and thus the move may not be welcomed. In medical education, the modified term used for capability is 'performance'. 'Performance' does not require a real life situation because of the patient safety issues, but a simulated environment to test judgements (248).

3. Roles

Professionalism is a multi-dimensional construct which has different levels, such as individual, interpersonal, institutional, and societal dimension. This shows that every role or position has some specific professional attributes associated to it, or some attributes become predominant in some roles. Doctors compartmentalize their personality to perform different roles, which is a concept of multiple identities (120). Compartmentalization means to activate in-group identity according to context (120). For example, in a clinical setting, they are recognized as doctors based on a set of professional competencies (120). In other contexts such as friendship groups, the basis for shared identity may be based on ethnicity, religious affiliation, or gender (120). The variation in professionalism can be owing to the variation in performance in a specific role. For example, communicating with a patient at individual level, or as a team leader in a workplace.

There can be some issues and barriers, associated with the roles of a doctor, such as size of a team, generational differences, gender, language, professional autonomy and practice, values and ethics, physical and emotional wellbeing, motivation, commitment, and professional learning (249). An example of a barrier can be at individual level, where a foreign doctor in Scotland, during communication skills has difficulty in understanding the Scottish accent of a native patient. The barriers and issues associated with different roles require training in role-playing exercises to smoothly perform in multiple roles, and how to switch roles (249). Moreover, these issues can be dealt with by seeking guidance from moral values, guidelines by regulatory bodies, understanding the local culture, and knowing limitations as a practitioner. Moral attributes of professionalism, such as trust, responsibility, empathy, and honesty are applicable to all the roles of a doctor (249). The training in different roles enable health professionals to balance between the ‘organizational professionalism’ and ‘personal professionalism’ (249).

The study respondents reported that the role of a doctor in his individual capacity is the most important role as a professional, and for interaction with his patients. The role as individual may be either as a scholar or as a scientist, as a clinician, and as a manager or administrator (26). All these roles require decision making

skills of a doctor, or his professional autonomy. The professional autonomy can at times, be limited or regulated by the organization or healthcare system. Professionalism, based on professional autonomy has been further divided into organisational professionalism (professionalism 'from above') and occupational professionalism (professionalism 'from within') (249). The autonomy of a doctor is not opposed to the autonomy of a patient. It means the autonomy of a doctor in order to protect the interests of his patient against the system. The example of autonomy is the strike of young doctors in Pakistan, in which they refused to work because of the difficult and unsafe working conditions. The doctors claimed that the strike here was against the system for the greater good and safety of patients.

In Scotland the dominant form of medical professionalism is 'organisational professionalism' as compared to 'occupational professionalism' in Pakistan. This has also been previously discussed because of the robust regulation by the GMC. However, doctors frequently engage themselves with these policies in creative and dynamic ways to find the best possible treatment and management options available for patients (249). Similar practices are also seen in Pakistan, but because of the weak regulation, the doctors have more leverage to practice autonomously. They can prescribe medicine, and plan patient management depending on patients' social status and requirements. For example, if the patient is poor, the doctor has an option to prescribe low cost medicine, which is not the case in Scotland due to free healthcare.

The study respondents also mentioned their teaching roles such as, 'facilitator' and 'assessor'. Some faculty members said that they find it difficult to switch from the role of facilitator to the role of assessor. These roles involve decision making, that is influenced by knowledge and understanding of different contexts, within which these professionals are working, as well as by their educational beliefs and values (249, 250). A list of factors which influence different professional roles is given in Table 31.

Table 31: Factors which influence the role of a doctor as an individual. Redrawn with modification from Gewirtz and Beijaard (249, 250).

Values and Ethics
- Market forces, Pharmaceutical industry
- Public versus private practice
- Individualistic versus collectivist practice

Emotional and Physical wellbeing
- Exhaustion
- Professional uncertainty
- Confusion
- Anxiety
- Mortification and doubt
- Frustration
- Anger, aggravated by tiredness
- Stress and students' misbehaviour
- Anxiety because of the complexity of the job
- Guilt
- Sadness
- Blame and shame at not being able to achieve ideals or targets imposed by others'

Motivation and commitment

Professional learning

Role of religion

Role of belief

Role of research

Teamwork is one of the important criteria for professionalism, which will be discussed later in detail under the theme for teams, but here, it will only be discussed from the point of view of 'roles' in team. Doctors play different roles in teams depending on their career level and training. The roles frequently change from morning shifts to night shifts, and with the change of workplace such as moving from wards to OPDs, and from OPD to ICU, CCU or OT. The doctors in this study viewed teamwork as very professional but observers, such as students viewed it differently. The students could appreciate the power dynamics working within the teams and how they were influencing the teams. The doctors, in this study, did not feel these power dynamics as they were all in senior roles. It was also notable that most of the success and failure of teamwork was dependent on the role of a team leader.

The study respondents from Scotland reported the concept of 'shared leadership' where the leader of the team changes with the expertise, which may not always be the consultant doctors (now have consultant nurses). It is still at its early stages

but majority of the consultants are now aware of this new type of role in teams. The data from Pakistan suggested that the structure of teams is still hierarchical and the team leader is always a consultant doctor because he is regarded as the most knowledgeable person about the disease process. One of the reasons for 'positional leadership' is knowledge, which is the power basis for a team leader. In Pakistan, other healthcare professionals are not trained as extensively as doctors, which lead to a huge knowledge difference, thus creating a power difference between doctors and other healthcare professionals. The positional leadership may be practiced until the training of other healthcare professionals is improved, so that they can take the responsibility, and become as knowledgeable in their fields, as doctors (251). Overall, the team working in Pakistan is poorer as compared to Scotland due to lack of appropriate training. It can be improved by promoting research activities and inter-professional education to improve collaboration among different healthcare professionals (251, 252). This requires an effort to convince the policy makers to fund and support to improve teamwork (251).

4. Approach towards patients

The most important interface of professionalism is the individual interaction with the patient. The study respondents said that the key in patient-doctor relationships is the one-to-one meeting and so the focus needs to be on developing skills for one-to-one interaction with patients. The regulatory bodies stress on a 'patient in partnership' approach, which is part of the patient-centred approach (39). The aim is to empower the patient and to reduce the power differential between the doctor and the patient, to help the patient to decide the most suitable treatment option for him/herself (39). The approach suggests providing patients with all information on disease process (39). The doctor needs to listen to the patient properly and to manage, accordingly (39). A professional doctor has to take care of a patient, as his/her first priority, irrespective of his/her religious, ethnic or social background, and to deal honestly with him/her (39). Moreover, the patient-centred approach requires doctors to communicate all treatment options, and to help the patient to select the one which suits best to his/her conditions (39).

The system-centred approach or more specifically the context-centred approach has been previously discussed under the main heading of 'healthcare systems'. The context-centred approach means that doctors need to be sensitive to the context. It is the practical approach towards a patient, which means to work within the constraints of the system in a balanced manner. The balance is between patients' versus public interest according to the available resources.

The study suggests person-centred approach as a holistic approach that includes physical, mental, and social dimensions of health. The World Health Organization (WHO) has set three important criteria in the definition of health, a state of physical, mental and social well-being (253). This implies a doctor to consider all three aspects, and not only to focus on the physical illness or the mental problems, but also to discuss the social issues, which the patient is confronting, or can confront as a result of treatment. This can be specifically associated with the diseases which are stigmatized in society such as, sexually transmitted diseases. The WHO definition of health can be used as a guiding principle for professionalism, which if carefully thought over, gives a broader perspective that professionalism is not just limited to the physical illness of a patient, but it also includes dealing his/her psychological fears, concerns, and social issues (253).

Communication skills are the most important components in approach towards a patient, but these can vary significantly depending on communication styles. The data suggests that communication needs to be context specific, for example, if a patient does not want information or does not understand the disease process, or if s/he wants the doctor to make decision for him/her, then the doctor may respond accordingly. The study respondents and some literature suggest that the medical model of communication skills may limit the interaction of doctors with their patients, because it is focused on task and advocates for a strategic approach, which is against the social or humanistic model (254). The empathy and altruism in medical model are moderated which may not allow doctors to establish rapport with patients. This task focused model of communication skills may serve well in busy clinics but may not satisfy patients on some occasions (254).

The variation in 'approach towards patients' is more in Pakistan as compared to Scotland. One of the reasons for variation in Pakistan is its size, which is more than

four times the size of Scotland. Factors which are associated with the size of the country are the resource constraints, doctor to population ratio, weak healthcare system, and corruption (251, 255). In Pakistan, these external factors influence professionalism of doctors and extreme variations can be observed from ideal (patient-centred approach) to the usual practices (doctor-centred approach). Figure 40 shows different factors influencing the approach of a doctor towards patient. The boxes on the right side of the figure shows the confounding factors and the arrows show the influences of one factor over another factor, such as, patient-overload leads to time constraints. In return, time constraints leads to less time to make rapport with the patient, thus leading to poor communication. Most of the factors mentioned in this figure are discussed repeatedly under different headings in the discussion chapter because of their complex inter-relationship with each other.

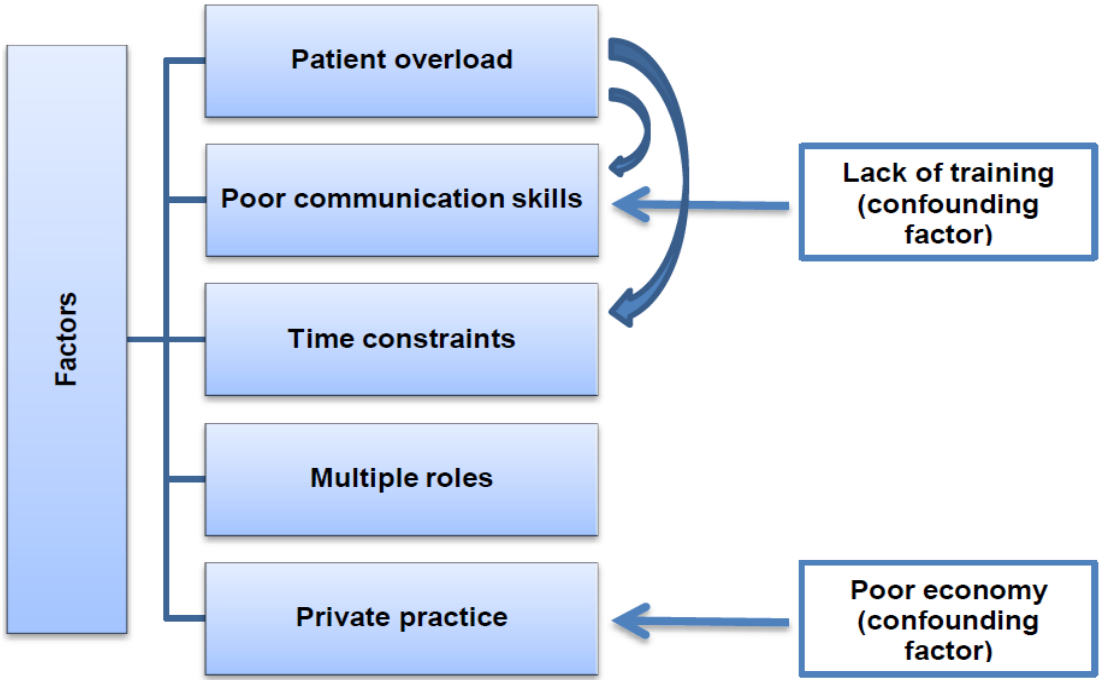


Figure 40: Factors leading to the difference between ideal and usual practice of 'approach towards patient', in Pakistan.

Representative statements for 'approach towards patients' by a doctor and two students from Pakistan (Case 5), are given below. The quotes are related to patient overload, privacy, and difference in approach of doctor in public and private sector.

> "The usual practice is different for trainee, house officer and consultant. The consultants are in haste and the problem is the workload. The reason is that OPD timings are from 8 am to 1 pm, and there are usually 150-300 patients waiting in an OPD. They can hardly give 30 seconds to each

> patient. So, it's very difficult to explain or council a patient in 30 seconds. Hence, workload is the main issue." (SA FP3 C5)

> "To observe the vaginal examination in our Gynae wards, the doctor used to tell us to let her first expose the patient, and after that we could enter the examination room. This was completely wrong; no one will ever want this to happen to her. It's so uncomfortable, and then so many students on the top of it." (FGD S C5)

> "Usually in Pakistan the division of patients is on basis of finances; one is poor and other, rich. You will be treated much better, if you are going to rich peoples hospital (usually a private hospital), where you pay lot of money. If you are going to some poor hospital, like 90% of hospitals, government hospitals or charity hospitals, then patients will not be treated well. I have observed bad scenarios in our charity hospital where the doctors did not behave properly with patients." (FGD S C5)

One of the doctors from Pakistan (Case 4) also mentioned the power differential between patient-doctor relationships, which is more in Pakistan. The representative statement is given below.

> "In our context in Pakistan or probably in other developing countries as well, there is a power differential between a doctor and a patient i.e. they are not at the same level. There is a hierarchy and a patient is considered to be comparatively in a lower status as compared to a doctor. The example, I would give for this is that when a patient and a doctor are communicating in a clinical context, and if a patient has to ask a clarification question, although it is his right to ask the question but he always ask the doctor and begin with, 'If you don't mind, can I ask a question?'. So this is the power hierarchy that exist between doctors and patients in our setup." (AJ FP2 C4)

5. Dealings with colleagues, teams, and other healthcare professionals

Dealing with colleagues is one of the important learning outcomes for professionalism (37). In Scotland, the study respondents reported that teamwork is organized and planned. The intra-team activity is more efficient as compared to the inter-team activity. However, there were few occasions when the coordination between teams failed or break up. An example of the communication break-up of inter-team activity was reported by a study respondent from Scotland. He mentioned a case of patient death in one of the Cardiac Care Unit (CCU). CCU in this particular hospital is considered the most efficient unit for its intra-team activity. In this particular instance, they found that the nurse was not available in the unit at the time of patients' death. On inquiry, the nurse reported that she was called for a mandatory fire drill by the hospital administration. She requested to her supervisor for a cover duty during the fire drill exercise, which was refused on

the reason of shortage of staff. The nurse made a judgment to attend the fire drill exercise, as she said that all patients were stable when she was leaving the CCU.

The study respondents from Pakistan reported weak teamwork because of inadequate training. The culture of teams is still hierarchical, where the consultant doctor is the leader of a team. The colleagues and trainees are also dealt according to the hierarchy. The study respondents said that some doctors are very knowledgeable and up-to-date but may not complete the full circle of professionalism because of weaknesses in communication skills, or lack of appropriate behaviour, which can negatively affect the team. They reported better intra-team functioning than inter-team or multi-disciplinary team function.

The team leader was appreciated as a role model for the rest of the team. The study respondents said that, the team tries to achieve standards, if the team leader exhibits professionalism. One of the important jobs as a team leader is to provide feedback to the team members on their performance, so as to improve their co-ordination and collaboration (256). The study respondents said that, mostly there is a formal mechanism for feedback but the informal feedback can be as effective as it does not have an element of assessment and is often more genuine and contextual. However, this feedback needs to be positively constructive with a balanced approach towards ‘support’ and ‘challenge’ dimensions shown in Figure 41 (256). This means that teams which work in challenging situations such as A&E or trauma require more support from their team leader. Similarly, team leaders who want to carry out high quality research activities, have to provide the appropriate amount of support to the team members.

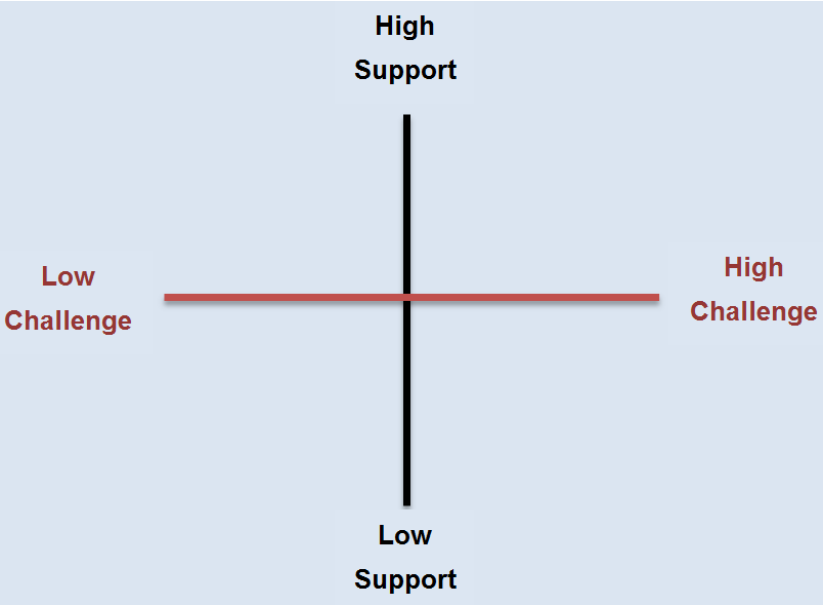


Figure 41: The 'support' and 'challenge' dimensions of feedback to improve team working. Original diagram, compiled from information in Knight (256).

The hospital administration influences the activity of teams within a hospital. The institutional ethos of two different hospitals affiliated to the same medical school may have many differences. The example is of the Case 5 from Pakistan, which is a private medical school. It has two teaching hospitals, almost 1 mile apart. The students reported many differences among inter-departmental teams. One hospital has a strict administration than other. The strict administration is seen positively by the students for their teaching and learning, because all the faculty members are available in wards, and regularly take part in the teaching and learning activities. Whereas the loose administration of the other teaching hospital is considered as having a negative influence on teaching and learning of students because the faculty does not come to wards on time and are late for classes. There is also an historical element to strict and lenient administration, as both these hospitals had different administrators over the last 8-9 years. The initial administrators laid down the tradition of strict and lenient administration which was then followed by the successive administrators of the hospitals, thus modifying the behaviour of the staff towards time management.

The students from Case 4 in Scotland also reported different approaches of hospital administration. This particular medical school has over 20 teaching hospitals. The students reported efficient teamwork in small hospitals as compared to the large hospitals in the city.

6. Self-regulation

Self-regulation is the hallmark of professionalism. All the doctors in this study and most of the students said that they self-regulate and observe most of the doctors and medical students regulating themselves. They reported that medical students and doctors self-regulate for their studies, knowledge, and skills components of their education but what is more important is their image as doctors.

The study respondents reported that few of the medical professionals are weak in self-regulation because of insufficient training in professionalism. They partly attributed the lack of training in professionalism to the environment of competition which has been created in the medical profession. Due to competition, the primary focus is on knowledge and skills components. The entire medical education in both countries is based on the 'outcome-based education' model, where professionalism forms the outermost circle and encompasses the knowledge and skills components. However, the data suggested that professionalism is still not given due emphasis, as compared to knowledge and skills components.

Table 32 shows a summary of different dimensions, and further typology of self-regulation identified by this study. The study respondents discussed about different domains of self-regulation such as technical and non-technical. The approaches towards self-regulation are similar to the learning approaches. They can be either, superficial, deep, or strategic. The study respondents mentioned different formal and informal methods of self-regulation, and shared situations and limitations to self-regulation.

Table 32: A summary of different areas of self-regulation which were mentioned by the study respondents from both countries.

Dimensions of Self-regulation	Further exploration
Stakeholders	• Patients • Institutions and organizations • Public • Family • Politicians • Media
Domains (Technical and non-technical)	• Knowledge • Skills • Behaviours • Attitudes • Practices
Level/Approach	• Superficial • Strategic • Deep (insight)
Range of depth	• Attribute • Behaviour • Attitude • Value • Belief
Types (Instruments)	Formal • Appraisal • Revalidation • Reflective portfolios • Feedback Informal • Attending conferences • Reading articles • Performance meetings • Informal feedback • Research activities • Religion or spirituality
Cycles	• External to internal cycle  • Internal to external cycle
Situations	Within hospital or healthcare facility • Colleagues • Teams • Students Outside hospital or healthcare facility • Family • Community
Difficulties and Limitations	• Collection of evidence • Searching for knowledge gaps • System weaknesses affecting regulation • Pressures (peers, family, community) • Validity and reliability issues with formal self-regulation instruments for example, appraisal • Lack of training • Too much regulation can inhibit innovation

In Scotland, a degree of self-regulation is imposed by the external regulator, GMC, such as appraisal and revalidation processes. This shows the role of GMC in directing and promoting the doctors in the UK towards self-regulation through external regulation. Their documents, such as 'Tomorrows Doctors' and 'Good Medical Practice' can be seen as evidence towards the move to promote self-regulation (37, 39). The GMCs' documents form the rules or guidelines of the activity system to promote self-regulation. This culture of self-regulation has also been supported by other healthcare bodies such as Royal College of Physicians by their document, 'Doctors in Society', and 'Scottish Doctors' by Scottish Deans' Medical Curriculum Group (SDMCG) (25, 32). However, the regulatory body cannot regulate doctors and medical students in their day to day practices. Therefore, doctors and students have to take responsibility for their regulation internally, so as to avoid lapses in professionalism.

The study respondents mentioned formal tools used to promote self-regulation. These included reflective portfolios, appraisal, revalidation, social media self-regulation (257, 258), staying up-to-date by promoting the culture of reading articles, and research activities. Like many other tools, these formal instruments have their limitations. Some doctors from Scotland considered the 'appraisal' process as a superficial exercise and reported that it has not served the purpose for which it was introduced. Participants also had reservations on the introduction of 'revalidation'. Some said that it may prove as superficial as 'appraisal' as no one may fail and others stated that no one may fail because they all are practising, and staying up-to-date. One of the issues with instruments for self-regulation is that it cannot be measured numerically, and so is based on subjective judgement.

The informal ways of self-regulation are the ones which are practiced by an individual for his/her own improvement and are not imposed by a regulating body. The study respondents from Scotland reported variety of informal tools for self-regulation such as, reflection and reflective writing, conferences, finding suitable training opportunities, peer feedback, reflection, reading and writing papers, and discussing clinical trials with colleagues. A representative statement by a Scottish doctor (Case 2) for self-regulation is given below.

> "On a day to day basis, I try to look for gaps in my knowledge, that's where I rely on experience and past recognition. I only practice one day a week, I recognise that, I am not as good as I used to be, so I have organised a system of decision support. I meet with my mentor every week when I am in practice. In medical school, we have seminars and meetings. It's about learning from each other. So, I think, it's a good way on a day to day basis of self-regulating. Moreover, I adhere to more 'formal' systems for self-regulation, like 'appraisal' and 'performance review'." (JK FP1 C2)

In Pakistan, there is no formal mechanism to promote self-regulation. It was strongly recommended by the study respondents that self-regulation needs to be promoted by the external regulator. The doctors also reported that the continuous medical education (CME) activity or credit hours system is required to keep them up-to-date after Post-graduation. This external regulation may guide them in improving their practices (259, 260). The development of culture of self-regulation by the external regulator requires a 'needs analysis' of the context of the healthcare system (259). Self-regulation is informally practiced by following the religious model however it does not provide any evidence. The data suggested that provision of evidence for self-regulation is important to show that a person is regulating him/herself. The faculty members from Pakistan mentioned that the UK model of 'appraisal' and 'revalidation' can be followed and imposed by the external regulator in Pakistan for the provision of evidence.

7. Image of a doctor in society and family

The study respondents reported varied perceptions of society about doctors. They said that these perceptions are changing rapidly. There is a variation across generations, and doctors need to adapt to different approaches depending on people's cultural backgrounds and educational experiences. The contextual nature of professionalism makes its perceptions 'relative' to the individual experiences.

The role of a doctor in society is more than that of a usual citizen. It is defined by contract of the medical profession with society, which includes elements of social accountability and social responsibility (31, 78, 227, 261). Doctors are among the most trusted professionals in society but recently, the market forces have widened the gap between doctors and society (32). These include the role of media, and privatization of medicine, that have led to superficial-professionalism (93). The gap is not very evident in Scotland, where health is still predominantly provided by the State, free of cost at the point of need. Thus, the perceptions of society, in

general are not as varied as in Pakistan, where the private sector is providing 65-70% of the healthcare facilities to the public.

In Pakistan, there is variation but mostly, doctors owe their responsibility towards society. It is reflected in the form of facilities in the private clinics or in the wards. The doctors from Pakistan reported that most of the doctors in their private clinics, practice ethically and professionally, and charge minimum fee from patients such as £3-8 per patient. Some of the doctors may consult with and operate on patients for free, if they realize that the patients cannot afford the fees. This shows the altruistic attitude of these doctors, as most of those who join a medical school and become doctors are usually highly conscientious (262). Moreover, the religious background also guides these doctors not to indulge in any unethical or unprofessional activity. However, these cases are under the iceberg and there is no hard evidence for any such cases, other than personal observations and anecdotes by the study respondents from Pakistan. The reason for these cases to be unnoticed is because of the religious belief of hiding the charity or good work where the concept is that charity is for God, and not to publicize it. This shows that the private sector is driven by economy, but there are historical and cultural forces in the form of the medical profession and religion, that guide doctors towards professionalism.

In Pakistan, there is polarization between the religious and liberal factions in society. The study respondents from Pakistan reported that these extreme views of society also determine the opinions about doctors. They said that society is judgemental, and perceptions about doctors depend on his/her appearance and religious beliefs. Some of the doctors, who may be responsible socially, may still not be considered good by a faction of society which does not share the same belief system with that doctor. The beliefs of doctors are judged by their physical appearance, and the type of their dress. For example, a native male doctor with local dress and beard may be considered religious minded while a doctor without a beard and wearing Western clothes may be considered as liberal. This creates complexity, but usually the rule is that in cities, it does not matter as much. However, in rural areas, it is preferable to keep local appearance such as, local dress. The dress and physical appearance are not seen as criteria for

professionalism by experienced doctors in Scotland because society is educated and majority has homogenous views. In Pakistan, there is difference in perceptions depending on the level of education. The analysis of the data suggested that urban areas and cities may have different perceptions about the social role of a doctor as compared to the rural areas and villages. However, the most important level of interaction is at the patient level and his/her satisfaction. In my view, an empathetic approach of a doctor towards patient can neutralise the effect of his/her physical appearance.

8. Limitations and conflicts

It is important for a professional doctor to know their limitations. The data suggested a variety of clinical situations where the guidelines and rules may not be clear while managing a patient and may need critical decision making by the practitioner. Moreover, the limitations and conflicts are not only specific to the clinical situations but also to the teams, colleagues, institutions, family, law, and broader society.

The study respondents said that, generally doctors are law abiding but there are few laws in both countries, where a doctor may feel conflict when practising medicine. Some of these laws are more relevant to specific specialities, such as a GP treating a drug addict while in comparison, an interventional radiologist did not mention it as a conflict because of his different job nature. The respondents mentioned two reasons for doctors being very law abiding which are related to each other. The first is that they enjoy a privileged position in society and abide law to stay in that privileged position. The second reason is that they are strongly regulated by an external regulator such as, GMC in Scotland. In Pakistan where there is a privileged position but weak regulation, at times doctors do cross the professional limits by taking advantage of their position in society.

The respondents mentioned five main dynamics which were influential in approaching a conflict situation and to resolve it. These are:

- Power
- Equality (balance)
- Equity (Justice)

- Dilemmas
- Cultural differences

The dynamics of conflict situations identified from this study have been explained with examples in Table 33.

Table 33: Dynamics of conflict situations reported with examples.

Conflict situation	Examples
Power (power dynamics)	• Conflict between trainer and trainees • Conflict between students' and teachers' priorities • Conflict between medical school and affiliated hospitals
Equality (Balance)	• Balancing time between patients and family
Equity (Justice)	• Conflict between doctor and patients' relatives interest for a specific treatment • Competition between different wards and doctors for specific facilities
Dilemmas	• Utilitarian ethics • Keep/breach confidentiality • Prescription of pills (underage girls, drug addicts) • End of life decisions • Uncertainty situation
Cultural differences	• Respect for elders, influenced by religion • Collectivist versus individualist society, affecting professional attitude of doctors and students.

The study respondents gave their opinions on different conflict situations and how they can be resolved. They said that some of the conflict situations are resolved by the power dynamics between different parties, where the powerful dictate the resolution, such as in terms of conflict between a consultant and a trainee. A third party can be involved to negotiate between the two conflicting parties, such as a regulator, or a senior colleague, or a hospital administrator. Another situation of power dynamic was a switch from powerful status to a more vulnerable position, for instance from a position of a doctor to the status of a patient.

Equality means to provide the same facility or treatment or approach to all the patients, colleagues, team members, family members, and society. The role of a doctor is most important while balancing the situation to resolve either his internal or external conflicts. The role can be either as a professional, or as a family

member, or as a member of society. The professional role requires balancing different agendas such as time for patients, colleagues, and for own professional development. In regard to patients, the balance can be adjustment of resources between patients and public, where the resources are distributed equally between all patients irrespective of their demands. The study respondents said that as family members, they sometimes compensate in giving time to family members on weekends or light work days. They said that doctors should equally meet the demands of society. Generally, society views doctors as self-centred, which doctors can balance by equally participating in different social activities.

Equity means not to maintain the balance but to adjust according to the needs and demands of the stakeholder. This adjustment is based on justice, and not on providing equal options to all stakeholders. Such resolution to conflict situations is more complex and challenging, and require more deep decision making processes as compared to the 'equality or balanced' approach. The difference between equality and equity is to prioritize. It can be understood with an example of 'triage rapid initial assessment by doctor' (TRIAD) to improve waiting time and processing time of emergency departments (263). The aim of such assessment is to prioritize, which patient to treat first, based on what they are suffering from. A gunshot or myocardial infarction patient will be treated first even if there are patients with fever and flu waiting before them. The principle of equality demands that patient, who come first need to be treated first, while the principle of equity is to first treat the patient with more acute disease process. The treatment priority in this case is not provided on the basis of equality, but equity. Another example of equity based conflict situation can be competition between different wards for surgery (OT) space, where the trauma department is given priority over elective wards, because of the acute nature of their job. As a general rule, the principle of equity is used for conflict situations which are more acute or life threatening, while equality based for more stable conflict situations. However, this rule cannot be generalized to all the complex situations related to professionalism.

The dilemmas are the grey areas of conflict situations which cannot be explained with equality or equity dimensions. The study respondents said that some grey areas in medicine are due to conflict of the medicine, or belief of a doctor with the

law of the country. There can be situations where doctors have dilemma whether to keep or breach confidentiality of a patient, if in case, he is harmful to himself or someone else. 'Utilitarian ethics' which means, 'to maximize good for the greatest number of people', can be used in case of such dilemmas, but needs careful thinking and prior consultation with colleagues, as it can be dangerous for the reputation of a doctor (264). Other such situation may be related to prescription of drugs for example, contraceptive medicine for underage girls. Moreover, the decisions for end of life situations can lead to difficulties. The situation can be complicated based on the consent and involvement of the family members, and freeing the ventilator machine for a more deserving patient. All these situations have an element of 'uncertainty', along with internal (beliefs) and external (law, medicine) conflicts of a doctor. An example of representative statement shared by a student from Scotland (Case 2) is given below.

> "My father is a GP and he deals with all the drug misuse in his area. He finds a conflict because lot of drugs are criminalized. That's the biggest problem he has in treating people because a lot of patients don't want to come in to admit it, of the fear that they will be reported to police. He finds it difficult when trying to deal with patients of substance misuse. It was quite interesting because he has changed his stance to decriminalization of all drugs." (FGD S C2)

The data suggested that the dynamics of working environment across cultures, including incentives, working hours, and working conditions can also lead to conflict situations. In Scotland, the working hours and working conditions of health professionals are much better than their counterparts in Pakistan. The standardized healthcare service has a better support system for doctors to avoid and resolve conflict situations. The time management and balance between personal and professional life in Scotland is much better as compared to Pakistan. The 10-12 times more doctor to patient ratio in Pakistan, along with emergencies due to war and terrorism, create conflicts in terms of prioritizing between patients, and treatment options for them.

There can be extreme situations such as in armed forces, warzones, or during an outbreak of contagious infectious disease where professionalism of doctors is tested, and may lead to conflict situations (265-268). In such situations, it is suggested, not to risk one's own life to show professionalism (265-268). This is where a professional doctor is in conflict with the a good doctor (265), when they have to decide between altruism or to moderate it. One of the study respondents

from Pakistan said that at the intention level, altruism is accepted, but at the action level where it becomes measurable, it has to be moderated in some situations so as to be within the legal and professional boundaries. In religious societies, such as in Pakistan, where professionalism is taught in the religious context, it can be put in a way that the religion also advice to "*first protect yourself and your body, and then help others*" (Translation of a Verse from Quran).

Such extreme situations are not observed in Scotland. However, the northern part of Pakistan, where this study was conducted, receives war causalities from Afghanistan, and also firearm and bomb victims of terrorism acts in the region. Moreover, the frequent outbreaks of contagious infectious diseases, such as measles, dengue fever, bird flu, and swine flu put professionalism of doctors under extremely stressful situation. The analysis of data from Pakistan showed that a Western model of professionalism needs to be researched in local context for its efficiency in extreme situations.

There was a universal demand by all study respondents for training in conflict situations. It was felt across both countries and equally by faculty and students that they are not formally well-prepared to deal with conflict situations. Conflict resolution is part of the informal training but this study suggests that it also needs to be explicitly taught because of the growing complexities of clinical situations, and an increase in law suits and complaints against doctors. The focus for such training may be on communication skills, and how to adapt to different situations. It is also shown by a recent document from the GMC that the public complaints against doctors have increased due to weak communication skills, as some doctors have yet not adapted to the patient-centred approach (119).

A phrase which was frequently mentioned by most of the study participants was 'talk to each other', in the reply to 'conflict resolution'. It has an historical and social element of how 'talking' can resolve conflicts. In medicine and clinical situations, there is a culture of gathering the views from colleagues and peers, and coming to some resolution. However in Pakistan, this study showed that doctors and medical students do not usually talk to resolve conflicts because of the inequalities and the imbalance in power structure. These imbalances and inequalities reflect on justice system in society. In Scotland, the resolution of

conflict through ‘talking’ is generally more effective because of training in professionalism. The study participants from Scotland showed more awareness about the difference between friends and colleagues, and showed a more professional behaviour in their workplaces.

In Scotland, the system is more standardized, and there are some loose frameworks which are used to resolve conflict situations whereas in Pakistan, the frameworks are in place but not effective. An example of one such framework, developed from data analysis of this study is given below.

- Take time to analyse the circumstances, keeping patient in the centre of the situation.
- Discuss with colleagues (especially if the doctor in conflict is young and inexperienced). Take their advice and make appropriate decision.
- Honesty: Being honest to the patient if a specific treatment cannot be offered because of the financial constraints. However, the message can be conveyed politely to convince the patient for the available treatment, which needs training in communication skills.
- Mostly problems may be solved at this stage but if not, then senior colleagues can be involved or external defence organizations can be contacted for help.

Limitations

The limitations of the study are as follows.

1. Nature of sample: The sample contained two groups: undergraduate and practicing clinicians. It was not possible to differentiate or sub-categorise the sample. Therefore, years of experience, individual expertise, variance in medical training, and other influences could not be taken into consideration.
2. Sample size: This is difficult to anticipate (the methodology does not incorporate a powers analysis), but saturation of data was achieved from the number of interviews and focus group discussions.
3. Credibility: There was a concern that the participants in the sample may not have correctly interpreted, or appreciated the questions asked. Therefore, when listening to the participant, I was evaluating the answer to be sure that statements were relevant.
4. Follow-up: Due to limitation of time, it was not possible to establish new questions from the data, and to undertake a second round of interviews that allowed the themes to be investigated in more detail.
5. Generalization: This qualitative study showed the contextual nature of professionalism due to which it cannot be generalized to other places. Moreover, it was not possible to have any part of the study replicated by a third party, or research collaborator. Therefore, I was mindful that the need for accuracy and risk of bias was a primary consideration.
6. Experimentation: Cultural Historical Activity Theory normally requires a study to be extended to an intervention stage, for example, teaching professionalism. However, this was not possible due to limitations of time, to observe if there can be any transformation in understanding professionalism with some teaching intervention.

Conclusion

Professionalism is the art of balancing the way an individual spends his/her life. This balance is not limited to professional life but also encompasses personal life. The balance is in all the themes outlined in this study, including the roles, the approach, in self-regulation, and in times of conflict. The situations of conflict can be because of imbalance, in which case balancing is the appropriate way of dealing with it though it is also about the right decision. In this case, the concept of 'equity' and 'equality' can be the guiding principles for conflict resolution, where equality is balance but equity is justice. Due to this, 'balance' was not taken as a main theme for professionalism because it was not relevant to most of the conflict scenarios, although balancing in roles, approaches and self-regulation can help in avoiding many conflict situations. The concept of 'equity' provides a solution to more complex situations but also requires more understanding of particular situations.

Cultural Historical Activity Theory provided a consistent framework for explaining different themes across both cultures. The framework of CHAT was used as a 'unit of analysis' for different cases. Cultural Historical Activity Theory considered professionalism as an activity that was influenced by culture, history, role of economics and religion, formal and informal curricula, and other observations in the healthcare setting. The use of theory helped in explaining the complex relationships of different themes with each other, and how they were influencing professionalism. Cultural Historical Activity Theory normally requires a study to be extended to an intervention stage, for example, explicit teaching of professionalism. However, this was not possible due to limitations of time, to observe if there can be any transformation in understanding professionalism with some teaching intervention.

This study included interviews from 36 clinical faculty members and six focus group sessions with 51 clinical years' students, from six medical schools. The study showed similarities and differences in understanding professionalism across Scotland and Pakistan. Mostly there were many similarities in professionalism because of the influence of the UK medical education on Pakistani medical

education. The few differences were due to the sociocultural variations and constraints of the healthcare system. These similarities and differences extended over nine themes; the nature of the healthcare system, models of professionalism, curriculum, teaching and assessment of professionalism, roles of professional doctors, approach towards patients and other healthcare professionals, working in teams, self-regulation, image of doctors in society and within families, and dealing with ethical dilemmas and resolving conflict situations in the work place.

One of the limitations of this study was that the only constant found in this study was the 'variation'. Every single individual, even from the same institution, had a different approach towards the same theme of professionalism. This can be attributed to the experiences of the individuals and the fact that most of the faculty members have their experiences based not only on one organization but many, with changes in job and postings. In this case, CHAT may not be applied at the organizational level but either specifically at the individual level or at a broader national level. It was also found that, in general, the approaches of the clinicians towards professionalism themes were mostly dependent on the workplace conditions and healthcare system in which they were working.

The perceptions of patients, public, and other healthcare professionals could not be sampled due to limitation of time, which would have added some more perspectives in understanding professionalism in greater detail. Future studies on cross cultural analysis of professionalism can include other groups for more perspectives on professionalism.

There was an observation that the ENT (Ear Nose Throat or otolaryngology) consultants across both countries from different medical schools had a polite approach towards colleagues and patients, even in busy situations. This led to a question: Do specific specialities have certain intrinsic cultural values and norms, irrespective of the country or context? Another reason for this question was the similarity in observations and perceptions of students about medical and surgical teams, that is, do medicine and surgery share some intrinsic values as disciplines, irrespective of the country or cultural effect? These questions could not be explored further in this study but may be used as a direction for future research.

This study has indicated that the doctors and medical students who participated, in both Pakistan and Scotland, have mostly similar perceptions about professionalism with a few dissimilarities because of differences in the culture, history, daily activities, and role of religion. There is a need for training in professionalism and this study might be considered as a pilot study to introduce a 'professionalism theme' in the undergraduate curriculum in Pakistan. Moreover, this study also found that faculty development programmes are required for training in different areas of professionalism.

Recommendations

Recommendations from this study are as follows.

1. The model of ‘process of professionalism’ should be taken as a practical guide, using self-regulation to manage conflicts, and for teaching professionalism.
2. The medical model of communication skills limits the interaction of doctors with patients. Communication skills training should be updated in both countries and guidance should be taken from sociological models of communication skills which provide a broad range of options for interaction with patients.
3. Both doctors and students should have training in self-regulation, conflict resolution, and difficult situations, for example treating a family member.
4. There should be training in inter-professional education, inter-team and intra-team working for a better performance at the departmental and organizational level. In Pakistan, there should be more training in teamwork to overcome poor team performances. Moreover, the policy makers in Pakistan should provide appropriate funding to improve teamwork.
5. The gap between formal, informal, and hidden curricula should be reduced to maintain consistency. Teaching hospitals and medical schools should collaborate to reduce the gap between theory and practices.
6. In Scotland, it was observed that the students from the bigger medical school, with many affiliated teaching hospitals, reported more variation in professionalism. This might be good for their early years as doctors but it revealed a gap in the standardization of faculty members which suggests the need for a robust faculty development programme.
7. In Pakistan, professionalism should be taught in the undergraduate curriculum. Moreover, faculty development programmes should be started for training in all areas of professionalism.
8. In Pakistan, a Western model of professionalism may not be totally appropriate. Therefore, it is recommended that a variant model for professionalism be developed which can address the local issues and how to

deal with them. The policy makers should support and fund research activities for development of such a model.

9. In Pakistan, self-regulation is practiced informally by seeking guidance from religion. However, evidence is required for self-regulation. Hence, the external regulatory body, the PMDC, should impose self-regulation formally through external regulation. The role of the regulator needs to be fair and robust to ensure the transparency of the process.
10. There is potential for seeking guidance from spirituality and religion in teaching professionalism. Considering the combination of teaching spiritual or religious beliefs with research evidence from the literature may have a strong effect in developing professionalism. This will also require the faculty to strive to reduce the gap between the formal and informal curricula so that students can experience congruence and consistency.
11. The healthcare system in Pakistan should focus on training other healthcare professionals in communication skills and counselling.
12. In Pakistan, both students and faculty members should be trained in social responsibility in order to improve the image of doctors in society. This step might be difficult to impose at national level due to geographical peripheries. However, a start can be taken from the medical schools and teaching hospitals which can be gradually extended to the geographical peripheries.

The participants' perceptions about professionalism had differences related to culture, history, daily activities, and role of religion. There is the perception of a lack of training in professionalism and a need to include it in the formal curriculum. A training programme could be organized and incorporated into the curriculum using the themes, models and process of professionalism, and adjusting it to the local practices and praxis of the healthcare system of the country.

Future Research

Some of the recommendations for future research work are as follows.

- Replication: A similar study in other cultures would establish the transferability and generalizability of the conclusions.
- Specific themes: Further work in the identified themes would reveal a greater understanding such as, healthcare system, self-regulation, law, patient expectations, good or professional doctors, teamwork, and image of a doctor in society.
- New themes: This research revealed some areas that were worthy of investigation. These included, causes of professional conflict (not always the same in every culture), and how individuals learn to resolve professional conflict. Moreover, this study showed that professionalism is a reflector of the healthcare system and thus it would be interesting to use complex adaptive system theories to understand professionalism in its broad context. The complexity theories will enable us, how a healthcare system adapts and self-organizes to different situations, and to show the variations in the trajectories of professionalism with time.
- Exploration of the topic with other methodologies: This study explored professionalism using a constructivist approach but new perspective can be added from the post-modernist view to understand how multiple truths develop and how they can be addressed in terms of formal, informal, and hidden curricula. Furthermore, this study could not use critical theory research because of time limitation, to explore the power dynamics in more detail. Therefore, I suggest exploring the topic from critical theory perspective to enhance our understanding of, how power dynamics influences professionalism.

Reflection

I completed medical degree and house jobs in 2007 in Pakistan. After the house jobs, I joined a medical school as tutor and worked there for three years. During my job, I also completed a Masters in Public Health from Pakistan in 2010. In clinical practice, it was sometimes difficult for me to know which professional position to take. This was because my medical training did not equip me adequately to behave as a professional, and the focus of our curriculum was only on scientific knowledge. As a tutor, I was aware that professionalism was poorly taught. When I came to the University of Glasgow in 2010, I observed that the medical curriculum had a theme for professionalism and students were explicitly taught about professionalism. The difference in culture of medical schools interested me, and I wished to understand the best practices in medical schools from both countries. My past professional experience and academic background made me a suitable candidate for this research project.

The experience of undertaking this study and then writing the thesis allowed me to develop a deep understanding of the research process, as well as, the topic of professionalism. One of the requirements of this thesis was to use more than one methodology and method. This meant that the selected methodologies needed to congruent, for in-depth findings from the study. The most difficult task was the selection of appropriate methodologies and it took me six months to develop a rigorous methodological framework. The alignment at methods level was easier than aligning two methodologies with each other. There were congruence issues in the philosophy while using more than one methodology. Initially, I studied grounded theory for carrying out this study because of its congruence with the research questions and clear data analysis techniques. However, methodological debates and disagreements revealed flaws and limitations in its use that had started when the founders of grounded theory, Glaser and Strauss, opted for different approaches to its use. Glaser's approach is known as 'purist' while Strauss is known for his 'constructivist' approach to grounded theory research (199). Moreover, I had an experience of using grounded theory in my Masters' dissertation, and I was aware of some theoretical issues, when developing a theory through it. This led me to search for other methodologies which could be

appropriately used as a main methodology, and also to search a basic methodology to support it. Other methodologies, which I studied in detail, were ethnography and action research but, finally, I selected case study research as the main methodology. I used qualitative research techniques, also known as interpretivist research, as the basic methodology. The reason for the selection of case study research was its openness in use and because it could be easily aligned with other research methodologies and methods. Moreover, case study also offered the possibility of 'multiple case studies', which helps to pursue individual cases whilst simultaneously developing a holistic picture of the situation. Thus, I was able to interpret data individually from all the six medical schools and also developed an overall picture of professionalism in both countries.

Meanwhile, during the advanced research methods (ARM) classes, I came to know about paradigms, or philosophical perspectives, in research and was interested in two: constructivism or interpretivism and postmodernism. After some detailed study, I realized that a postmodernist approach might not be advisable in medical education because a postmodernist perspective, in its true sense, negates the quality assurance procedures such as validity, reliability, and triangulation. However, medical education, as a subject, advocates for quality assurance that is, arguably, more traditional than a postmodern approach would afford. The postmodernist approach uses 'crystallization' which states that reality has multiple dimensions and a variety of shapes or forms (269). Hence, it may lead to multiple truths (269). These multiple truths should be considered while interpreting results, for an enhanced understanding of the phenomena under investigation (269). Such an approach seemed limited in professionalism studies where there is an element of strong external regulation and tendency to follow rules and guidelines devised by the regulatory bodies. So, although reality can take many forms and interpretations, any approach that advocates deviation from traditional routes or a bypassing of rules and regulations that can lead to multiple interpretations of professionalism, may not be the most appropriate at this time in medical education. The medical profession cannot be practised independently, for self-interest, without caring for the public. The rules and regulations are there to ensure public and patient interest. My view is that professionalism is about submission to the rules and regulations and those who do not cooperate may be

labelled as unprofessional or a lapse in professionalism cases. Therefore, I adopted a constructivist approach which has an element of authenticity. The constructivist approach allows reporting of different realities based on the perceptions and experiences of the study participants in a manner, appropriate to the topic of the study.

I used two data collection methods in this study, semi-structured interviews (SSIs) and focus group discussions (FGDs). The FGDs gathered very insightful data but the semi-structured interviews were organized around professionalism themes from the literature due to which the respondents were only commenting on those themes and not beyond them. An in-depth interview format would have enabled me to explore new themes for professionalism but the quality assurance of in-depth interviews is not as traditionally robust as SSIs and so I was reluctant to use it, thinking that the information gathered from in-depth interviews might not be as focused as SSIs. The SSIs provided more control of the interview process and information gathered from it was focused on in-depth exploration of the selected themes. Therefore, broader themes of professionalism were selected so as not to miss important information and also because SSIs offer robust quality assurance procedures as compared to in-depth interviews.

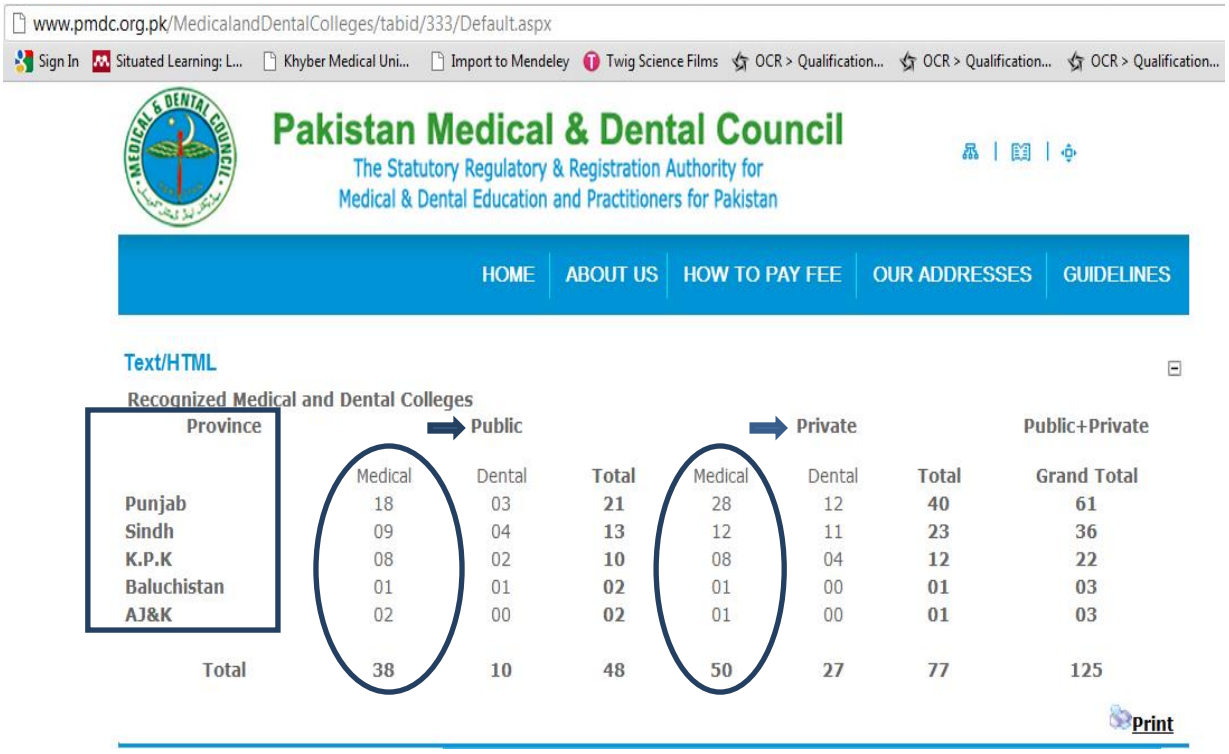
There were many options of data analysis techniques but the selection of the most appropriate option was difficult due to similarities in the processes of these techniques. The selected data analysis technique needed to be aligned and congruent to the rest of the methodology. I studied different analysis techniques that included framework analysis, narrative inquiry, discourse analysis, content analysis, and thematic analysis. The two most suitable options for this study were the framework analysis and thematic analysis. The use of Cultural Historical Activity Theory (CHAT) provided a theoretical framework for the analysis of the data which later helped in the development of themes of professionalism. Content analysis was used as a part of the thematic analysis but I did not find it very useful. I could have also used narrative analysis, had narrative inquiry been adopted as a methodology. I found discourse analysis more appropriate for the secondary analysis of the data but it was too complex to follow in a limited time. I found thematic analysis as the most appropriate data analysis technique because of its

openness, due to which it was easier to align it with the rest of the methodology. Thematic analysis also provided a broad range of coding techniques that were used in different cycles of coding with predefined protocols.

Overall, the constructivist paradigm, along with case study as a methodology and thematic data analysis provided an open ended and methodologically aligned approach towards the construction of the study design and understanding professionalism. I do not make claims for broad generalisation from this study but I hope that it might further inform future studies and further extend our understanding of professionalism in medical education.

Appendix

Appendix 1: Sampling of medical schools from Pakistan



www.pmdc.org.pk/MedicalandDentalColleges/tabid/333/Default.aspx

Sign In | Situated Learning: L... | Khyber Medical Uni... | Import to Mendeley | Twig Science Films | OCR > Qualification... | OCR > Qualification... | OCR > Qualification...

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The Statutory Regulatory & Registration Authority for Medical & Dental Education and Practitioners for Pakistan

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Text/HTML

Recognized Medical and Dental Colleges

Province	Public			Private			Public+Private
	Medical	Dental	Total	Medical	Dental	Total	Grand Total
Punjab	18	03	21	28	12	40	61
Sindh	09	04	13	12	11	23	36
K.P.K	08	02	10	08	04	12	22
Baluchistan	01	01	02	01	00	01	03
AJ&K	02	00	02	01	00	01	03
Total	38	10	48	50	27	77	125

Print

Total public sector medical colleges in Pakistan =38

Total private sector medical colleges in Pakistan =51 (website now shows 51 medical colleges instead of 50. In the KPK Province, one medical college has been added to the list so there are 09 medical colleges in KPK on the updated website, instead of 08, as mentioned above.) (217)

Three cases were selected from Pakistan. Ratio 1:2 (one public sector medical college for almost two private sector medical colleges)

(*In Pakistan, medical schools are known as medical colleges. Dental colleges are not included in this study)

Appendix 2: Protocols for the study

Transcription protocols

Signs Used and their meaning in the interview and FGD transcripts

()	I have identified some consistent and conflicting themes, and also the areas which were closely related to the CHAT.
() Highlighted	I have commented on the sequence of reasoning behind the respondents' thought process.
‘ ‘	Used at places where the respondents' language has shifted from third person pronoun to first person, either explaining his own account or someone else's perceptions.
;	Used at places where the respondent has stopped for a second or few without starting the new thought, and then continued with the same thought process.
[]	Used within the bracket (), for an abbreviation.
{}	Used at places where a similar pattern or theme was identified in some other interview or FGD, so the code of that transcript was written here to have a reference for similar themes at the analysis and interpretation stage.
…	Used at places where the respondent has shifted from one thought process or argument to another without completing the initial one.
… ()	Used at places where the respondent has shifted from one thought process or argument to another without completing the initial one. The bracket shows my first hand interpretation, analysis and explanation, for this thought process.

Protocols for coding scheme

First cycle of coding

1.	Underline a word, line, sentence or paragraph or pick up single 'key words'.
2.	Give a label or code to the underlined word, line, sentence or paragraph.
3.	The label for code may come from three sources (182, 183): • My understanding of the data, where the words are explaining the code in a more meaningful manner. • The participant, from the words within the data transcripts (also called 'in vivo coding'). • The words from the literature.
4.	Keep on using the constant comparative method of data analysis, that is, to compare different transcripts with each other for similar patterns (182, 183).
5.	Write memos to describe the relationships between codes and to explain the theme (182, 183).
6.	Save memos as MS Word file in the folders made for the relevant themes (182, 183).

Second and third cycle of coding

1.	Underline a word, line, sentence or paragraph or pick up single 'key words'. Use a different colour marker or a highlighter to differentiate the axial code from the open code (182, 183).
2.	Give a label to the underlined word, line, sentence or paragraph. The label can be same or different from the open code according to the condition.
3.	The label may come from three sources (182, 183): • My understanding of the data, where the words are explaining the code in a more meaningful manner. • The participant, from the words within the data transcripts (also called 'in vivo coding'). • The words from the literature.
4.	Keep on using the constant comparative method of data analysis, that is, to compare different transcripts with each other for similar patterns (182, 183).
5.	Write memos to describe the relationships between codes and to explain the theme (182, 183).
6.	Save memos as MS Word file in the folders made for the relevant themes.
7.	Search for the relationship among codes (formation of axial codes)

Protocols for categorical and thematic analysis

1	The names for categories came from three sources (182): • My understanding of the data, where the words were explaining the category in a more meaningful manner. • The participant, from the words within the data transcripts. • The words from the literature.
2.	The categories may be able to help in answering the research questions.
3.	The categories need to be sensitive to the data, that is, the reader of the category should gain some sense of their nature (182).
4.	The categories need to be exhaustive, that is, enough categories to encompass all relevant data (182).
5.	The categories need to be mutually exclusive, that is, a relevant unit of data can be placed in only one category (182).
6.	The categories need to be conceptually congruent, that is, all categories need to be at the same conceptual level or same level of abstraction should characterize all categories (182).
7.	Keep on using the constant comparative method of data analysis, that is, to compare different transcripts with each other for similar patterns (182).
8.	Data Saturation: Stop the formation of categories when no new themes can be identified from the data (182).
9.	Arrange the sub-categories under categories.
10.	Arrange the categories under a core category or theme.

Appendix 3: Codes list

Table 34: Criteria mentioned for themes of professionalism by faculty members and students across six Scottish and Pakistani medical schools (Codes list).

Theme	Description	Criteria
Professionalism	Dynamic	**Faculty** 1. Doing the right thing 2. Do no harm 3. Standards 4. Multiple dimensions with different levels 5. Fiduciary 6. Altruism 7. Context 8. Not a subset, it's a whole thing 9. Contract with society 10. Reorganizing yourself 11. Ethical, principles of ethics 12. Knowledge, attitude, and behaviours 13. Respect 14. Honesty 15. Responsibility 16. Communication skills 17. Professionalism forms core for being doctor 18. Balancing conflict between patient and public interest (System-based approach) 19. Roles (as a doctor, as a manager, as a scholar) 20. Assessment drives professionalism (exam or assessment-centred approach of doctors) 21. Duty (consistently showing professional attributes) 22. How to manage in limited resources **Students** 1. Competence 2. Treating person (person-centred approach) 3. Following guidelines 4. Separate roles 5. Approachable 6. Confidentiality 7. Not to be judgemental
Approach to patient	Context-centred approach	**Faculty** 1. Patient in partnership 2. Formal interaction 3. Avoid overfamiliarity 4. Be sensitive to the context (context-centred) 5. Treat as equal as humans 6. Patient-centred approach 7. Observations in exam are biased as it's simulated situation 8. Cultural variations (religion, patient level of education, gender influence, language, etc.) 9. Doctor-centred communication **Students** 1. Context 2. Person-centred 3. Tidy Dress

		4. Listen carefully 5. Empathy 6. Variation in communication styles due to generational differences, and high versus low-pressure situations
Experiences of doctors, as patients	Contextual Mostly good experiences. Few bad experiences due to: • Less empathy • Weak communication skills Extreme variations in Pakistan	**Faculty** 1. Biased views, as doctors are usually in privileged position as patients, because of being from the same profession 2. Task-focused approach 3. Felt vulnerable 4. Switch between power dynamics 5. Doctors make false assumptions about doctors as patients 6. Felt ignored 7. Not engaged with patients 8. Observed weak communication skills **Students** 1. Patients are judgemental 2. Patients want to be communicated 3. Patient like multiple treatment choices to be given to them. 4. Patient expects empathy, including respect, responsibility and honesty 5. Patients feel doctors are busy 6. Good doctors adapted to the way, patient felt 7. Variation in views with different doctors in different situations 8. Public or private hospital (private setups more caring, as incentive driven)
Dealings with colleagues, teams, and other healthcare professionals	Contextual	**Faculty** 1. Time limitations 2. Personal agendas 3. Leader's role and power dynamics 4. Size of the team 5. Training 6. Finances 7. Individuals' personality 8. Respect for teams and colleagues 9. Sharing and caring 10. Different roles such as 'facilitator', and 'assessor' 11. Cultural influences 12. Transition time 13. Fragmented rota 14. Flexibility 15. Working conditions 16. Communication skills 17. Hierarchy 18. Respect 19. Barriers are breaking 20. Cooperative and collaborating 21. Depends on the individual person 22. Ignorance of other's job 23. Level of interaction 24. Main change in use of vocabulary **Students** 1. Generational difference

		2. Speciality area 3. Team size 4. Role of leader 5. Personal conflicts 6. Boundaries 7. Peer support 8. Professional courtesy 9. Nature of job of colleague determines his respect 10. Type of demands made, that is, ideal or realistic 11. Trained in communication skills or not 12. Difference in attitude between public and private setup 13. Family issues 14. Small group discussion can improve interaction 15. Research activities can improve collaboration
Self-regulation (SR)	Mostly informal for students, and formal for faculty members, that is, imposed by an external regulator, such as GMC. In Pakistan, it's informal and guidance is pursued mostly from religion	.**Faculty** 1. Self-regulation is must, being professional without self-regulation is not possible 2. Self-regulation is a fluid concept 3. Self-regulation is hallmark of professionalism 4. Formal 5. Informal 6. Appraisal 7. Revalidation 8. Criticism of the formal self-regulation instruments 9. Reflection 10. Multi-source feedback 11. Mini-CEX 12. Portfolio 13. Explicit teaching of professionalism 14. External regulation 15. Equal representation of non-doctors in regulatory committees 16. Peer feedback 17. Reflection 18. Experience 19. Role modelling 20. Peer pressure 21. People judge self-regulation by knowledge, that is, knowledge is improved or not 22. Role of religion in informal self-regulation **Students** 1. Peer and teacher feedback 2. Different standards so difficult to use instruments 3. Discussion with peers 4. Experience 5. Diary writing to prioritize tasks 6. Stay up-to-date 7. Self-regulation for knowledge gaps is easier than communication skills 8. Social media 9. Image in public 10. Role of culture 11. Role of religion in informal self-regulation
Society and Family	Varied perceptions and expectations	**Faculty** 1. Society expect higher personal and professional standards

		2. Mutual respect 3. High social status 4. Trusted, honest 5. Society expects doctors to know everything about medicine 6. Being a doctor is just a job with certain skills 7. Government expectations from doctors is different from people's expectations from doctors (that is, system based approach versus patient-centred approach) 8. Demands changes from individual to group, to country level 9. Standardized practice in the UK 10. Accountability 11. Provide evidence to society, in the form of self-regulation 12. Difference between different systems 13. Public feel intimidated by cleverness of doctors 14. Image of doctor in society 15. System is not fool proof 16. Don't treat family members 17. Concept of multiple identities/ separate roles 18. Generational difference 19. Follow the system, don't treat family members 20. System works, don't be harsh on family, avoid aggressive treatment 21. Give confidence, opinion, reassurance but not treatment 22. Tension when treating physician is not picking up disease 23. Family wants to save bit of time by asking for advice 24. Family expect time and care 25. Cultural difference 26. Conflicts may arise **Students** 1. Very high expectations and respected 2. Regulatory bodies are asking for too much regulation 3. Different standards in different countries leads to differences in professionalism 4. Slight lapse in professionalism can make big news, role of media 5. Image of doctor in society 6. Public demands responsibility 7. Family usually need reassurance 8. Lack of knowledge of disease process can put students in awkward situation 9. Medical students enjoy relationship as family members, not as doctors 10. Lack of service structure negatively affects professionalism
Conflicts	Manage conflicts according to context	**Faculty** Situations 1. Uncertainty 2. Difficult patient 3. Difficult colleague e.g. underperformance 4. Power 5. Finances

6. Hierarchy
7. Breaching confidentiality
8. Destitute asylum seeker
9. Patient belief
10. Self-prescription
11. Boundaries
12. Different experiences
13. End of life
14. Extreme situations
15. Ownership of responsibility
16. Formulistic approach of law
17. Grey areas
18. Withdrawing treatment

Resolution

1. Doing the right thing
2. Gather evidence and then engage
3. Talk about it
4. Don't avoid seeing difficult patients
5. Documentation
6. Flexible system
7. Training
8. Patients are not friends (keep professional attitude)
9. Discuss with colleagues
10. Face conflict, gather evidence, stay upfront
11. Respect patient beliefs
12. Reconciliation

Students

Situations

1. Personal
2. Interpersonal (colleagues and teams)
3. Balance between personal and professional life
4. System fault (healthcare system)
5. Law and legal conflicts
6. Language barrier
7. Extreme measures may be taken to resolve conflicts in public sector medical schools in Pakistan.

Resolution

1. Talk
2. Mutual understanding
3. Post-conflict meetings
4. Avoid personal issues

Appendix 4: Format of questions for interviews and focus group discussions

Initial questions for interviews and focus group discussion

1. How do you think a professional doctor should approach their patients? (or relatives or carers of their patients).
2. What is the usual practice which you observe around when doctors communicate with patients? Is the practice the same what you think, it should be like or is it different?
3. How do you think doctors should regulate themselves to improve professionally?
4. Do they actually self-regulate themselves in reality? What are the usual practices which you see?
5. How do you find doctors, usually dealing with their colleagues?
6. How do they act in teams in their clinical settings?
7. What are your views on how does society look at you as a doctor/or medical student? What are their expectations from you?
8. Do you think that you are able to fulfil those expectations?
9. How do the doctors define their professional limits and legal boundaries?
10. How do they make sure that there actions are according to the law?
11. How do they resolve issues and difficult situations which may arise in their work?
12. How do doctors treat other health care professionals?

Modified questions for interviews and focus group discussion, with categories from the literature

1. Can you describe what professionalism means to you in the context of a doctor?

Categories addressed

- Attributes of a professional doctor (criteria for definition).

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2. How do you think a professional doctor should approach their patients? (or relatives or carers of their patients).
3. What is the usual practice that you observe when doctors communicate with patients? Is the practice as you expect? (Any example?).
4. What is your experience of the doctors when you were a patient? Was it the same as you would expect from a professional doctor? (Any example?).

Categories addressed

- Respecting the patients' autonomy.
- Respecting the patient confidentiality and privacy.
- Acting in a responsible fashion towards patients.
- Being attentive to the needs of patients.
- Showing compassion towards one's patients.
- Treating patients fairly and without prejudice.
- Being empathetic when caring for patients.

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5. How do you find doctors, when dealing with their colleagues/trainees?
6. How do they act in teams in their clinical settings?

Categories addressed

- Respecting colleagues.
- Acting in a responsible fashion towards colleagues.
- Working well as a member of team.
- Providing advice to colleagues when required.
- Treating colleagues fairly and without prejudice.
- Showing leadership skills and initiative.
- Being accessible to colleagues.

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7. How do doctors treat other health care professionals? (For example, a nurse, dentist or a homeopathic doctor, etc.).

Categories addressed

- Treating other health care professionals fairly and without prejudice.

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8. Do you think doctors should regulate themselves to improve professionally? If yes, how should they do it?
9. How do you self-regulate yourself to be a professional doctor?

10. Do you think, other doctors actually self-regulate in reality? What are the usual practices which you observe?

Categories addressed

- Being accountable for one's actions.
- Behaving honestly and with integrity.
- Communicating in a clear and effective manner.
- Behaving in a reliable and dependable way.
- Being receptive to constructive criticism.
- Having a positive attitude towards professional development.
- Reflecting on one's actions with a view to improvement.
- Not using one's professional status for personal gain.
- Taking a dedicated approach to one's work.
- Being sound in judgement and decision making.
- Avoiding substance or alcohol misuse.
- Making effective use of the resources available.
- Looking after one's own health and well-being.

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11. What are your views on how society regards you as a doctor/or medical student? What are their expectations of you?
12. What are your views on how your family regards you as a doctor/or medical student? What are their expectations of you? (e.g. giving medical advice to family).
13. What are the difficulties/stress that this creates for you? Can you give an example?

Categories addressed

- Being mindful of one's personal appearance.
- Behaving with composure.
- Confirming to social norms.

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14. How often do you think, the doctors work within their defined professional limits and legal boundaries?
15. Have you ever felt a conflict between practising medicine and the law?
16. How do doctors resolve issues and difficult situations which may arise in their work? (for e.g. ethical situations related to patients, students, colleagues or teams and system or administration).

Categories addressed

- Adhering to professional rules and regulations.
- Being aware of one's limitations as a practitioner.
- Being able to manage situations in which there is a conflict of interest.
- Functioning according to the law.

Appendix 5: Ethics Approval

University of Glasgow | College of Medical, Veterinary & Life Sciences

25 October 2012

Dear USMAN MAHBOOB

MVLS College Ethics Committee

Project Title: What interpretations may be made about the criteria for a global definition of professionalism in undergraduate medical education in different cultures?
Project No: 2012083

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Andrew C Rankin
College Ethics Officer

Professor William Martin
Professor of Cardiovascular Pharmacology

R507B Level 5
School of Life Sciences
West Medical Building
Glasgow G12 8QQ Tel: 0141 330 4489
E-mail: William.Martin@glasgow.ac.uk

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