

Management of professionalism matters by foreign returned doctors in Khyber Pakhtunkhwa province

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Abstract

Objective: To determine the management of professionalism issues by foreign returned doctors who are practicing clinicians after returning from abroad.

Methods: The qualitative study was conducted in tertiary care hospitals of Khyber Pakhtunkhwa province from January to August 2016. Purposive sampling technique was used to include foreign returned doctors who shared how they managed professionalism matters in context of contrasting cultures at home and abroad. The participants were interviewed in-depth and the audio records were transcribed verbatim. The data analysis generated codes that were consolidated under categories and then themes.

Results: Interviews with ten foreign returned doctors led to 20 codes that resulted in eight categories out of which four main themes were developed namely; Foreign Cultural influence that observed how their stay abroad have influenced their practice methods. Experience, showed how personal experiences of the interviewees helped forge their practice rules in Pakistan. Social Contract theme included the ways in which foreign returned doctors understood and accepted the concept of social contract in Pakistan as compared to west and how they adapted accordingly. Wise Man Approach included the help sought and received by foreign returned doctors from their senior colleagues in managing and adjusting to societal norms regarding professional behaviours in Pakistan.

Conclusion: There are multiple dissimilarities between the socio-cultural aspects, practices and knowledge of foreign returned and local medical practitioners. There exists a gap in knowledge with regards to their clinical practice between foreign returned and local doctors. To authors knowledge foreign returned doctors face substantial challenges with adjustment in Pakistan.

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Introduction

Professionalism has been viewed as a collection of essential skills of doctors since Hippocrates' time. The acknowledgment of medical professionalism as a multifaceted communal paradigm makes the framework, topographical setting and values important deliberations in any conversation of professional conduct.¹ Various studies done on the topic of migrating doctors have observed that doctors who travel to the European countries usually return after their higher-level training overseas.^{2,3}

Last half century has seen a steady increase in physicians migrating from developing countries to developed countries. Approximately 30-35 % of practicing physicians and international medical

graduates working in England are from developing countries.^{4,5} In comparison the percentage of foreign returned Pakistani doctors is only 5-10%.⁶ Extensive research has been done regarding adaptations made by migrating doctors during their stay in developed countries. Reciprocating studies observing adjustments foreign returned doctors make during their stay in Pakistan are lacking.

The rationale of this study is that there is limited evidence to support the argument that professionalism thoughts and qualities from Western nations are fully adaptable to other cultures. There has been a question on western framework of professionalism in non-western contexts in a view that applies in new settings.

In this paper, we explore the ways by which foreign returned doctors managed professionalism issues in cultural context. The purpose is to explore how cultural change effects professionalism of medical doctors.

Challenges documented will be of value to both local and international doctors which may act as a guideline for future.

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Methods

A qualitative study was done in tertiary care hospitals of Khyber Pakhtunkhwa from Jan 1st to 31st August 2018. The participants included those doctors who had stayed abroad for a minimum of five years and were now actively working as practicing physicians for at least two years in Pakistan. Anyone failing to fulfill any of the above criteria was excluded from the study. Purposive sampling was opted to gather data based on our previous knowledge and judgment about the participants

Data Collection and Analysis: Permission was taken from the ethical review committee of Islamic International Medical College application number Ripah/ERC/18/0277. Data was collected according to the procedure outlined in Figure-1. Two pilot interviews were done to improve the quality flow and order of questions. Foreign returned Pakistani doctors were contacted in person, via email and telephone. Willing participants were enlisted for the study after being briefed in detail about the nature and purpose of the study. Written informed consent was taken and persons were interviewed. Interviews were recorded followed by detailed transcription of the interviews.

A thematic analysis of the data was performed, that involved following steps:

A thorough read and careful listening of data (called transcription) notes was made regarding the initial impression. This was followed by a much in-depth review of the interviews. Pertinent word, phrases, sentences and sections in transcripts were then categorized and coded. The ideas, concepts and theme were coded to fit into categories. In our study, categories were developed using content analysis in which similar chunks of text were ordered or placed proximally. This helped in identifying the relationship between categories and subcategories. Following coding and categorization, themes were evaluated for repetition and links and covert themes were established

through interpretation and reflection. Finally, correlation between themes was identified and results were summarized to be presented in the form of matrix tables to compare themes or categories.

Quality of data was assured by associating all narratives using triangulation. All the results and discussions were shown to the participants for validation. Transcripts were sent to study participants to ensure all the points that they had mentioned were adequately addressed. Data was checked by the lead author for generation and extractions of codes and themes respectively. Finally, data was reviewed by two qualified medical educationists to establish credibility.

Results

Out of the ten doctors interviewed two had studied and worked in the United States of America, seven in the United Kingdom and one had trained and worked in Canada. The group consisted of three emergency medical specialist, two general surgeons, one Rheumatologist, Infectious disease specialist, Endocrinologist, Psychiatrist and Otorhinolaryngologist. Twenty codes were generated from the in-depth interviews that led to nine categories and were finally presented under four themes (Table-1)

Discussion

It was observed that most physicians used their prior experiences, help of their seniors or their foreign cultural influences to deal with professionalism related matters. In its broadest sense, medical professionalism encompasses all aspects of the higher attributes of being a physician but it might be understood differently by members of the medical profession itself. Even leading medical organizations have different interpretations and attributes of the elements contributing to medical professionalism.^{7,8} Medical professionalism is a blend of moral commitment and core behaviours. As medical practice becomes increasingly globalized, students, physicians and patients move among different countries and in doing

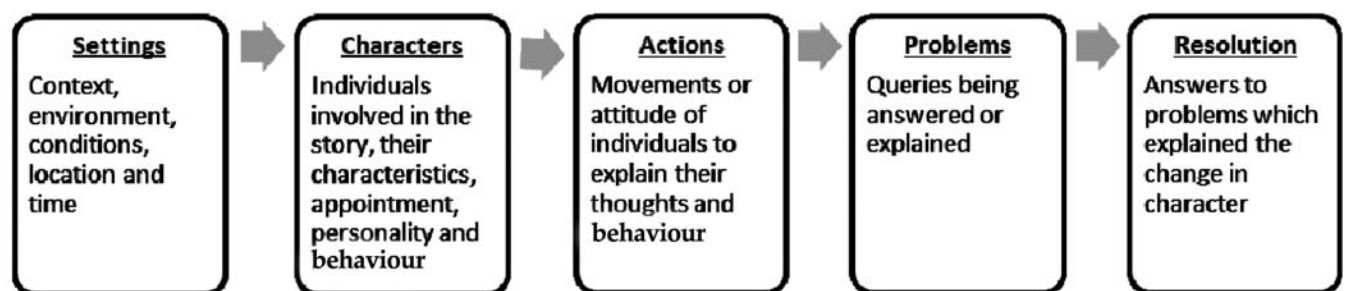


Figure-1: Procedure for data collection.

Table-1: Codes, themes and representative statements for the management of professionalism by foreign returned doctors.

Sr. No.	Code	Frequency	Category	Theme	Representative Quote
1	Practical Improvements	7	Foreign Cultural Strengths	Foreign Culture Influence	R6" in Pakistan establishing patient identifying checklists prior to surgery is still not followed "(participant 9)
2	More Communication	9			R4: "after gathering the facts I went to the family and explained about the procedure and they got comfortable." (participant 6)
3	Learning And Teaching	10	Contract		R10: "I teach my experiences to my students" (participant 3)
4	Doctors Attitudes	6	Cultural Adaptations	Experiences	R1: "I become more authoritative here" (participant 4)
5	Religious Practices	10			R5" In the west there was no involvement of religion but here there is religious abuse in management of professional issues" (participant 10)
6	Cultural Specific Skills	6			R1: "they are not very good in dealing trauma in their country... we are good because we have more practice here" (participant 8)
7	Managerial Differences	10	Administrative Adaptations		R8: "People don't come on time even if they are warned" (participant 7)
8	Duty Performances Differences	8			R6: "The most bothering thing for me was to see that the duty of a doctor was being performed by the nursing staff and the worst part that I have learnt is administration could not control it" (participant 5)
9	More Communication	7	Foreign Cultural Strengths		R7: ""communicating with patients in Pakistan is still not followed" (participant 1)
10	Learning And Teaching	10			R10: "I teach my experiences from foreign hospitals to my students" (participant 2)
11	Responsibilities	7	Duty Performances	Social Contract	R6: "No one here wants to be responsible for what they have signed up "(participant 9)
12	Skills Set	5			R1: "Nurses and doctors would like to take skills learning trainings, if they get assurance of their promotion" (participant 4)
13	Rules	6	Contract		R5: "Rules and regulations of the hospitals should be strict to make processes smooth" (participant 2)
14	Timings	9			R8: "Some of the doctors come late even if they are asked for several times"(participant 3)
15	Management Skills	7	Continuous Learning Environment	Wiseman Approach	R3: "The doctors here need to get trained about their use of protocols and management issues" (participant 5)
16	Process Learning Skills	10			R7: "top of the line is the nursing training for handling patients that needs to be addressed."(participant 4)
17	Self Assessment	6			R9: "even what I am practicing is guided and assessed by my seniors " (participant 5)
18	Monitoring And Evaluation	9			R1: "Formulation and implementation of rules and protocols is not the only solution, my seniors advised me to implement it" (participant 1)
19	More Surgeons	5	Workload Management		R2: "More support and surgeons are required here" (participant 10)
20	More Assistants	8			R3: "there are less assistant staff, my seniors advised me to make proper plans to involve staff in processes" (participant 7)

so, may encounter existing local beliefs regarding professionalism. The main issues raised during this study were related to the attitudes of doctors', nurses, intensive care unit staff and even the patients. Everyone had their own relevant views for these domains.^{9,10}

In our study, under the theme of 'influence of foreign culture', the respondents emphasized to have more training of doctors, nurses and other supporting staff especially to improve the overall practices for example maintenance of pre op check list. Limited finding about the influence of foreign culture in the form of trainings have been reported in the literature.^{11,12} There is one perception among doctors that main cause is due to lack of formal training during postgraduate teaching of

professional behaviours and may well be the cause of it here as well. In Asian countries there is no focus on teaching professional competence.¹³

In the context of the theme, experiences it was learned that compromises were made by the foreign returned doctors with regards to what is accepted as patient privacy and consent. Participants observed that these aspects were not given due weightage in consultations. In addition, participants reflected that they adapted due to involvement of hospital administration. This observation was also made previously where the patient's perception of informed consent and Pakistani physician's perspective on informed consent were taken.¹⁴ A study conducted by Schwartz showed that

adaptability to workplace changes was regarded as essential for Asians, who were considered culturally less flexible.¹⁵ This may well represent a counter-cultural response, which again demonstrates doctors' keenness to challenge cultural barriers in order to help patients.^{14,15}

The theme social contract highlights that while there was a culture of continuous medical education in west that transcended the barrier of seniority and experience, it was relatively unheard concept in Pakistan where the acquisition of new skills and improving clinical acumen through workshops and conferences was considered by seniors to be time consuming.¹⁶ Additionally healthcare staff are neither encouraged nor incentivized to acquire better skills. It was suggested that incentivizing promotion and monetary benefits would go a long way in encouraging health care workers to learn newer skills. Previously it was observed that linking promotion and financial gains as well as personal prestige with continuous professional development in west has been invaluable in firmly establishing a culture of professional growth and continuous education.¹⁷

One of the ways to adapt in Pakistani culture was by taking the support of senior staff members and learning from their experiences in managing the culturally different environment of Pakistani hospitals. This was observed under the theme of Wiseman approach.¹⁸ A member of the group shared how the positive attitude and guidance of senior faculty members helped ease his transition from west to Pakistani medical setup. A similar approach has been previously observed that senior faculty members playing a mentoring role helped apprehensive young fellows in making a smooth transition from culturally different setups.¹⁹

Strengths and Limitations

There is limited local literature available on the management of professionalism issues by foreign returned doctors. The scope of this study can be broadened by including participants who have returned not only from west but also from Middle East and Australia. This may lead to the compilation of views of doctors coming back from wider part of globe. Further studies can also compare the management of professionalism issues by foreign return doctors among different specialties to see if there is any difference of opinion regarding such matters between surgical and medical professionals.

Conclusion

There are multiple dissimilarities between the socio-cultural aspects, practices and knowledge of foreign

returned and local medical practitioners. There exists a gap in knowledge with regards to their clinical practice between foreign returned and local doctors. They face difficulties in adjustment with the administration of hospitals of Pakistan. However, there are advantages for foreign returned doctors as the patients perceive them to be more knowledgeable, skillful and professional.

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