Original Research Article

Assessment of Attitude Toward Professionalism Among General Physicians of Primary Health Care Centers at Abha and Khamis Mushayt, Saudi Arabia

Abstract

Background: Medical professionalism is considered, in modern clinical practice as the basis of the social contract between physicians and their society. It encompasses a wide range of values such as altruism, accountability, excellence, duty, service, honor, integrity, and respect for others. It has been researched extensively in the Western world, but only a dearth of studies exist in Saudi Arabia and the Middle East. ***Method***: A cross-sectional study was conducted on 157 physicians working in primary health care centers in Abha and Khamis-Mushayt cities of Saudi Arabia. The study tool was a self-addressed validated questionnaire. ***Results:*** Participants in the study were 157 general physicians, of whom 63.7% were males. The Saudis were 84.1%. The mean of experience of work in years was 3.5 years. Only, 50.3% had training in medical professionalism training, whereas 49.7% did not receive any training in professionalism (the mean number of training sessions was 3.1). The mean score of professionalism was 109.1 (out of a potential total of 130 points). Participants with High professionalism were 49%, while 49.7% were found to have moderate professionalism, and only 1.3%, was with poor professionalism. Factors related to a significantly positive association with professional behavior were; higher age, being married, being non-Saudi, higher qualifications (like Diploma/MSc), increased practice experience, and professional training one is involved in. ***Conclusion:*** The participant physicians reported high levels of

professional behavior. However, there is a need to focus on addressing job satisfaction factors to improve participants' practice attitude and subsequently increase professionalism.

Keywords: Professionalism; Attitude; Primary Health Care; Physician; Abha; Khamis Mushayt; Saudi Arabia

Introduction

The fast-moving and pressurized medical practice environment have made the care for patients complex for the health workers (1) both in the community and clinical care settings. As a result, ways of meeting the patients' needs have set a pace for healthcare institutional expectations. These expectations are aimed at care quality, timeliness, and safety (2). Health workers' behavior and attitudes towards practice and patient care that are components of medical professionalism largely define and address these expectations. If the medical profession is to stand and public trust gained and maintained, ensuring medical professionalism is key (3).

Medical professionalism is the basis of the social contract between physicians and their society. This professionalism entails professional behavior as an observed conduct that describes the values and standards of the profession. Good medical practice requires that the professional behavior of the medical professional be developed as a responsibility to patients, colleagues, and society (4). Doctors are expected to use their knowledge and skills to meet the needs of their patients and to place those needs ahead of other considerations, most notably self-interest. Doctors always have a formal duty and responsibility to behave in a manner that promotes patient and societal trust. This duty applies not only in clinical practice but also in the integrity of medical research and how medical students and residents are optimally prepared for medical

careers (5). Recently, there has been an emphasis on defining, teaching, and assessing medical professionalism (6) with an aim of strengthening medical professionalism.

Gruess (7) stated that professionalism is a culture-sensitive construct and, therefore, is perceived and expressed for local customs, beliefs, and cultures. Professionalism must be taught through the formal curriculum in the form of planned teaching and learning sessions and be assessed throughout the continuum of medical education (7). Additionally, Paul (8) noted that Professionalism is a core competency of physicians. Clinical knowledge and skills (and their maintenance and improvement), good communication skills, and a sound understanding of ethics constitute the foundation of professionalism. Professionalism among medical learners and practicing physicians is important because patients, medical societies, and accrediting organizations expect physicians to be professional, and professionalism is associated with improved medical outcomes (8). Therefore, the relationship between physicians and their patients reflects professionalism and is the center of quality health care (9).

Although much attention is being devoted to the question of professionalism in medical education and practice, there is no common understanding of what is meant by medical professionalism. The word professionalism frequently carries with it so many implications, complexities, and nuances (10). According to the Accreditation Council for Graduate Medical Education, professionalism is defined as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population (11). On the other side, the Association of American Medical Colleges identified four major attributes that physicians should possess for the practice of medicine; these are being altruistic, knowledgeable, skillful, and dutiful (12). Moreover, the American Board of Internal Medicine has required that those seeking board certification demonstrate that they have acquired

the values of professionalism, which ‘‘aspires to altruism, accountability, excellence, duty, service, honor, integrity, and respect for others’’ (13). Swick stated that medical professionalism consists of those behaviors by which physicians demonstrate that they are worthy of the trust bestowed upon them by their patients and the public since they are working for the patients’ and the public’s good (10).

All of these definitions seem to be speaking to the same thing; however, their constructs of measurement vary. As such, there is a rich array of measuring tools for professionalism. However, few of them address professionalism as a comprehensive construct. Furthermore, few instruments meet the minimal criteria of content validity and reliability that would support their use for academic assessments (14). Some of the researchers that have used these existing tools report varying findings. The 30-item questionnaire that was developed by Campbell et al. (15) is believed to be representing a single component of professionalism. In a study conducted in Iran, the overall level of professionalism among residents was reported to be of a moderate level (16) while that the study findings from Egypt showed that professionalism is multifaceted and there were variations in the attitudes towards different items in the study (17).

Findings from one of the Saudi Arabian studies indicated that significant improvements were needed as far as attitude for primary care medical staff is concerned; communication and stress recognition with regard to patient safety culture needed to be well addressed (1). The aim of this study, therefore, was to assess the attitude of professionalism among primary health care physicians in Abha and Khamis Mushayt cities and suggest areas for improvement and equipping. This study was guided by the following objectives;

- To assess the attitude of physicians towards different components of professionalism of primary health care centers in Abha and Khamis Mushayt cities.

- To identify factors associated with the attitude of physicians towards professionalism among primary health care physicians in Abha and Khamis Mushayt cities

Material and Methods

This study used a cross sectional study design and was conducted from October 2017 and May 2018. The study took place at 55 primary health care centers in Abha and Khamis Mushayt Cities, which are the two major cities in Aseer Region. All of the physicians recognized by the Ministry of Health at the primary health care centers in Abha (N=108) and Khamis Mushayt (N=49) cities were invited to be part of this study. These Physicians were approached by the researchers and a pre-designed structured questionnaire was provided to them after the explanation about the purpose and scope of the study was done. Only physicians registered or recognized by the Ministry of Health primary health care in Abha and Khamis Mushayt Cities were included in this study. Physicians unwilling to participate and those belonging to other specialties were excluded from this study.

An already existing questionnaire designed by Camp et al., (18) was used in this study and was participant-self-administered. This tool is comprised of 2 sections; the demographic characteristics (age, gender, nationality, qualification, years of experience in primary health care) part and the professionalism in medicine Survey part. This former part comprised of 3 scales for assessment of professionalism among students, physicians, and faculty members. Participants' responses on the second part were scored as 1 (correct answer) and 0 (incorrect answer). The total scores for each component as well as the total sum up of all components were calculated and the percentage was calculated for each participant. Those who obtained >80% of the total scores were considered to have "high" professionalism, whereas those who obtained 60- 79%,

were considered to have “moderate” professionalism. However, those who obtained <60% of the total score were considered to have poor professionalism.

Data were analyzed using the R-Statistical Software version 3.4.1. Categorical data were summarized using frequencies and displayed using tables and bar-graphs. Continuous data were summarized using the median, range, mean and standard deviation (SD). Both types of data were displayed in tables and graphs. Continuous data were approximately normally distributed. The effect of categorical and continuous variables on the outcome variables was determined using multiple generalized linear Poisson regression. The level of significance was set at $p \leq 0.05$.

Results

As shown in table 1, One hundred fifty (157) general physicians were included in this study; 100 (63.7%) being males and 57 (36.3%) females. The mean and range of age of the participants were 31.2 $\pm$ 6.42 years and from 24 to 52 years respectively. Sixty-four percent of the participants were married while 35.7% were single. The majority (84.1%) of the participants were Saudis and only 15.9% were non-Saudis. The most prevalent qualification was MBBS (93%), followed by Diploma/MSc (5.1%) and MD/Fellowship (1.9%). Regarding years of experience in Primary Health Care Centers, the mean was 3.5 years with a median experience of 30 years. 50.3% of the participants reported having training in professionalism whereas 49.7% did not have any training in professionalism. Of those, who had training, the mean number of training sessions was 3.1 (SD = 2.14).

Table 1: Socio-demographic characteristics of participants.

Characteristic	Frequency (N =157)	Percentage (%)
Gender:		
Males	100	63.7%
Females	57	36.3%

Age in years mean ± SD (median)	31.2 ± 6.42 (30)	
Marital status		
Married	101	64.3%
Single	56	35.7%
Nationality		
Saudi	132	84.1%
Non-Saudi	25	15.9%
Qualifications		
MBBS	146	93%
Diploma/Msc	8	5.1%
MD/Fellowship	3	1.9%
Experience years in PHCC mean ± SD (median)	3.5 ± 2.99 (3)	
Training received		
Yes	79	50.3%
No	78	49.7%
Number of Training Sessions (if training was received): mean ± SD (median)	3.1 ± 2.14 (3)	

As shown in figure 1, 49% of the participants scored high professionalism, 49.7% scored moderate professionalism, and only 1.3% scored "Poor" professionalism.

Figure 1: Distribution of participants by professional level.

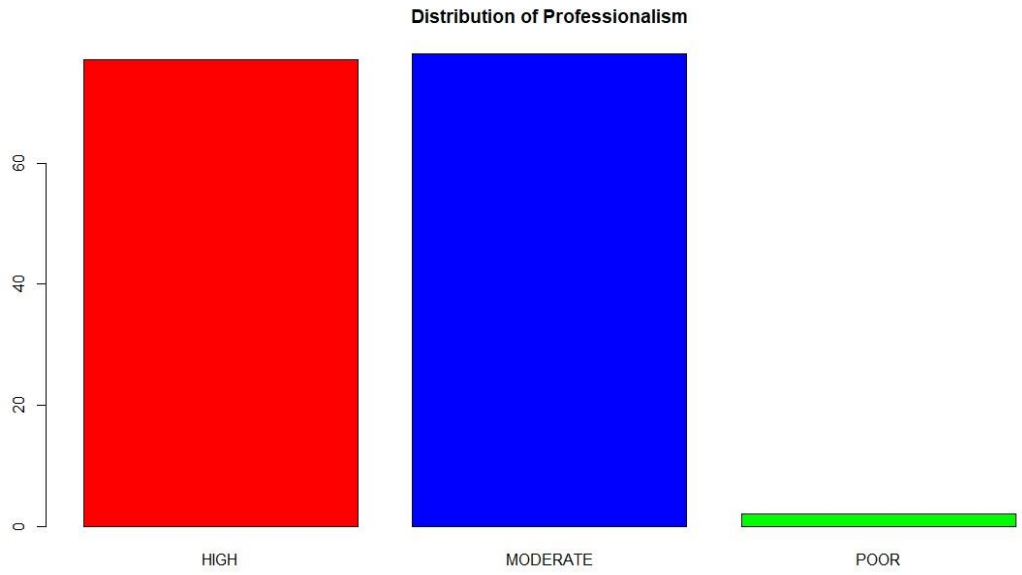

Table 2 shows that more than 80% of participants agreed that job insecurity, family life interference, lack of training like workshops, and training of undergraduate students during clinic are the main factors affecting professionalism level.

Table 2: Attitudes with determinants of professional behaviour amongst participants

Statement	**Agree**	**Disagree**	**Don't Know**
Do you agree that job insecurity can affect professional behaviour?	148 (94.3%)	0 (0%)	9 (5.7%)
Do you agree that job interfering with family life can affect professional behaviour?	130 (82.8%)	24 (15.3%)	3 (1.9%)
Do you think that overload of work can improve the professional behaviour?	55 (35%)	96 (61.1%)	6 (3.8%)

Do you think that error committed in workplace can improve the professional behaviour?	72 (45.9%)	55 (35%)	30 (19.1%)
Do you think that lack of training sessions like workshops can result in affect professional behaviour?	137 (87.3%)	15 (9.6%)	5 (3.2%)
Do you think that situational stressors can improve the professional behaviour?	66 (42%)	82 (52.2%)	9 (5.7%)
Do you think that training of undergraduate student during clinics can improve professional behaviour?	135 (86%)	11 (7%)	11 (7%)
Do you think that language barrier not affect professional behaviour?	59 (37.6%)	92 (58.6%)	6 (3.8%)
Do you think that age and gender of patients have any implication on professional behaviour?	86 (54.8%)	61 (38.9%)	10 (6.4%)

As shown in table 3, utilizing a Poisson regression modelling for the total professionalism score to estimate its effect on different variables, age was significantly associated with increased professionalism score (*OR = 1.01, P < 0.001*). Being married was associated with higher professionalism (*OR = 1.04, P = 0.012*) and so was being non-Saudi (*OR = 1.07, P = 0.001*). Also, a significant positive effect on professionalism was noted for higher qualifications (Diploma/MSc) (*OR = 1.09, P = 0.011*) and for increased experience in PHCC (*OR = 1.01, P < 0.001*). Expectedly, receiving training on professionalism has significantly improved professionalism scores (*OR = 1.06, P < 0.001*) and this improvement was better as more sessions were attended (*OR = 1.02, P < 0.001*).

Table 3. Poisson Regression Analysis results on the effect of sociodemographic variables on Professionalism score

Factor		Odds Ratio	95% Confidence Interval	P value
Age		1.0053	1.0030 to 1.0076	< 0.001
Gender (Male)		1.0281	0.9965 to 1.0608	0.082
Marital Status (Married)		1.0411	1.0089 to 1.0744	0.012
Nationality (Non-Saudi)		1.0689	1.0263 to 1.1118	0.001
Qualification (Reference)	**MBBS**	1	NA	NA
	MS/Diploma	1.0889	1.0191 to 1.1620	0.011
	MD/Fellowship	1.0693	0.9598 to 1.1871	0.222
Years of experience in PHCC		1.0101	1.0051 to 1.0150	< 0.001
Training in professionalism		1.0554	1.0243 to 1.0875	0.001
Number of training sessions		1.0162	1.0093 to 1.0231	< 0.001

Table 4 in the appendix shows that more than 50% of participants agreed that they 'should seek active roles in professional organizations and allow patients to elaborate' while 'communicating well their results' to them with empathy. Also, more than 50% of doctors agreed that they have to communicate well and collaborate respectably with other colleagues, follow institution policies, accept constructive criticism, engage in self-assessment, and improve timekeeping.

Discussion

Medical Professionalism is a relatively recent concept that was coined some fifteen years ago (19). It is a backbone of modern medical practice (20) and a determinant of medical institutions' competitiveness (21) with an established positive effect on clinical outcomes (8). The findings of the current study illustrate high reported levels of professional behavior among the physicians surveyed. The majority (98.7%) of the respondents reported moderate or high professional behaviors and attitudes. Most of the professional attitudes that were scored highly by the participants are should seek active roles in professional organizations, allow patients to elaborate while communicating well their results to them with empathy, communicate well and collaborate respectably with other colleagues, follow institutional policies, accept constructive criticism, engage in self-assessment, and improve timekeeping. At least 50% of the participants agreed with all these attitude statements. This observation indicates a trusted level of professionalism that is reassuring both to the medical profession in Saudi Arabia and patients. These results are also consistent with those of local and regional studies (21). However, as noted in the introduction of this paper, professionalism is a multifaceted and complex concept that involves considerable interaction between physicians, patients, society, and regulatory bodies (4). In this study, we focus on the reported, rather, than the observed behavior that constitutes the essence of medical professionalism that should encompass professional values and standards (4).

An important finding of the current investigation is that formal training in professionalism could substantially enhance professional behavior among physicians working in Primary Health Centers in Saudi Arabia. Such training could be provided in variable formats, such as a one-day or several days conference, crash courses, or via eLearning. More than 85% of

our sample of doctors agreed that training both postgraduate and undergraduate students in professionalism would positively impact their professional behavior when they qualify as practicing clinicians. International literature is consistent with these views (22). A recent study in Riyadh indicated that Saudi undergraduate medical students were mostly satisfied with their pre-knowledge of medical professionalism and were in favor of learning about medical professionalism during their college years (23). Subsequently, new models of professionalism training that include the use of webinars and e-learning have even been developed with excellent rates of success and satisfaction amongst trainees (24). Such models are claimed to be effective at a low cost and could well be utilized in professionalism training in Saudi Arabia and the Middle East.

Experience in clinical practice and age were also important factors in encouraging professionalism among the participants. The older and more experienced physicians were more likely to exhibit higher professionalism than the younger and less experienced physicians. The positive association between professionalism in clinical practice and physicians' experience was even reported by other researchers around the world (25). Numerous and intuitive explanations for such an association could be theorized; experienced physicians would certainly capture the essence of professional behavior through their contact with many patients over the years. Additionally, they would be more able to effectively apply their knowledge and skills to identify and meet the needs of their patients. Their ability to enhance the patient-doctor trust would be better than that of their less experienced counterparts. Moreover, older physicians would seem more respectable to patients, specifically with their proficiency and resilience in using theoretical capabilities effectively in terms of everyday clinical practicalities (20). Furthermore, senior physicians, generally, possess better communication skills which have an established positive

effect on professionalism (26). Such skills are guaranteed to improve patients' satisfaction and perception of physicians' competence (9) which are central characteristics of medical professionalism (27).

Although overall the attitude of the participants was good and evidence shows that it can be learned, several factors reported by the participants can hinder good attitude, the participants reported that that job insecurity, family life interference, lack of trainings like workshops, and training of undergraduate student during clinic may affect one's attitude towards their practice and the patient care. These factors motivate one's performance at work and unless they are well taken care of their performance will deteriorate with a subsequent decline in attitude towards patient care. Therefore, for one's attitude to be good factors affecting job satisfaction need to be well attended to. This assertion agrees with the study findings from the study by AlMaani and Salama (1) and Tay et al. (3).

This study has the following limitations: First, self-reported professional behavior may not necessarily equate to actual observable professional conduct. Secondly, in this research design, it is difficult to gauge against social desirability or the Hawthorne effect which is the change in behavior in consequence of being observed or assessed (28,29). Future research into determinants of medical professionalism should incorporate longitudinal design and more objective measurement of professional behavior among doctors. Further studies should also incorporate in their objectives the effect of patient complaints on the medical professionalism of doctors and investigate the perspective of Saudi patients on the issue of medical professionalism. Despite the limitations noted, the study remains unique in enhancing and maintaining the momentum in professionalism research in the Arabian region. One substantial strength to the

current study is the use of the highly reliable and internally consistent tool (the professionalism in medicine survey) to a large and representative sample of physicians.

Conclusions

The findings of the current study add to the evidence that already exists in pursuit of improving professionalism in medical practice. In Saudi Arabia physicians generally have a high attitude towards their practice and a high overall professional level. However, a few facets of practice and individual preferences have to be worked on to improve the overall professionalism score among the primary health care physicians in Saudi Arabia. Some of these aspects are job insecurity, family life interference, lack of training like workshops, and inadequate training of undergraduate students during clinic times. Through this study, the promotion of the concept of 'medical professionalism' in undergraduate Saudi curricula and postgraduate Saudi continuous medical education events is recommended. Additionally, financial, and logistical support for academic and clinical research of medical professionalism in Saudi Arabia is recommended.

Ethical approval

Ethical approval to conduct this study was sought from the head of the research ethics committee at every primary health center. The study commenced at each center immediately after approval was obtained.

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Appendix

1. Table 4: Attitudes towards different professional domains among participants

Domain	Item	Agree (n, %)	Disagree (n, %)
Just distribution of finite resources	You have right to minimize disparities in care due to patient age, race, gender or cultural.	91 (58%)	66 (42%)
Increasing scientific knowledge	You can force the participation of their patients in clinical trials.	76 (48.4%)	81 (51.6%)
	You should seek active roles in professional organizations.	144 (91.7%)	13 (8.3%)
Honesty with patients	It is not required for you to explain what is being done for the patient during examination or procedures.	27 (17.2%)	130 (82.8%)
	You should allow the patient to elaborate about his condition.	139 (88.5%)	18 (11.5%)
	You should communicate purpose and results of investigations to patients well.	152 (96.8%)	5 (3.2%)
Improving Access to care	You should not communicate accurate patient information to physicians from other departments when required to do so.	38 (24.2%)	119 (75.8%)
	You may coordinate patient care efficiently with other health professionals and physicians.	155 (98.7%)	2 (1.3%)

	It's not required by physicians to collaborate with other health care workers in order to achieve optimal patient care.	25 (16%)	132 (84%)
Improving quality of care	You should follow institutional policies and procedures.	154 (98.1%)	3 (1.9%)
	You should arrive on time to scheduled appointments and activities.	154 (98.1%)	3 (1.9%)
	It's unnecessary to participate in peer evaluations of the quality of care provided by colleagues.	40 (25.5%)	117 (74.5%)
	You should accept constructive criticism and develops goals for improvement.	150 (95.5%)	7 (4.5%)
	You should be willing to work on quality improvement initiatives.	145 (92.4%)	12 (7.6%)
Maintaining appropriate relationship with patients	You should maintain confidentiality of patients.	147 (93.6%)	10 (6.4%)
	It's not required by physician to respect patient's autonomy and right to be involved in his/her own management.	17 (10.8%)	140 (89.2%)
	You should communicate management options to patients in a clear understandable way taking into account the patients' opinions.	157 (100%)	0 (0%)
	You should be understanding body language as important as verbal communication in the physician patient's relationship.	154 (98.1%)	3 (1.9%)
	You should display empathy in dealing with patients.	154 (98.1%)	3 (1.9%)
	It's unnecessary by physician to summarize the information given for the patient in small quantities with concrete explanations.	24 (15.3%)	133 (84.7%)

	You should be concerned about the safety of patients.	157 (100%)	0 (0%)
	You should communicate efficiently and in a clear understandable and compassionate way with patient's families.	157 (100%)	0 (0%)
Maintaining appropriate relationship with colleagues	You should respect other physicians and professional colleagues such as nurses, medical students, residents and subspecialty fellows.	157 (100%)	0 (0%)
	You should collaborate well with nurses and other health care workers.	157 (100%)	0 (0%)
Maintaining professional competence	You should undergo recertification examinations periodically throughout their career.	145 (92.4%)	12 (7.6%)
	You should do self-assessment.	156 (99.4%)	1 (0.6%)
	You should not accept responsibility for own professional action.	53 (33.8%)	104 (66.2%)
Maintaining trust by managing conflicts of interest	You should put the patient's welfare above the physician's financial interests.	135 (86%)	22 (14%)
Fulfilling professional responsibilities including Self-regulation	It's not required by physicians to report all significant medical errors they observe to hospital, clinic, or other relevant authorities.	45 (28.7%)	112 (71.3%)
	It's not required by physicians to report all instances of significantly impaired or incompetent colleagues to hospital, clinic or other relevant authorities.	42 (26.7%)	115 (73.3%)