ISSN 1560-7607 / ISBN 978-99950-52-05-8

CAMBODIA DEVELOPMENT REVIEW

A publication of CDRI—Cambodia's leading independent development policy research institute

VOLUME 22, ISSUE 1 MARCH 2018 $4.00

# PERCEPTION OF MEDICAL PROFESSIONALISM AT THE UNIVERSITY OF HEALTH SCIENCES, CAMBODIA

## Introduction

Healthcare quality is on the national agenda. The Ministry of Health, the Medical Council of Cambodia, the public, development partners and NGOs working in the health sector have expressed great concern about the quality of medical education and the quality of healthcare delivered in the country. A policy roundtable on Medical Professionalism in Cambodia co-organised by the Cambodia Development Resource Institute (CDRI) and the National Institute of Public Health (NIPH) in August 2015 identified challenges and solutions for improving medical practices in Cambodia. Notably, support for medical schools to enable faculty to strengthen the ethics curriculum and train medical practitioners and students in ethics and professionalism was brought to the fore.

*Most medical students would rather work in the public sector than the private sector. Phnom Penh, Dec 2018*

CDRI, in partnership with the Faculty of Medicine at the University of Health Sciences (UHS), has carried out action research to assess the self-reported level of medical professionalism among medical students and medical faculty at UHS (Chhim forthcoming). The study was based on the assumption that a high standard of medical ethics education in medical schools will lead to better professional conduct, better patient experience and better health outcomes. This raised two questions: What is the level of understanding about medical professionalism among medical students? How is medical ethics taught at UHS?

The project aimed at drawing attention and providing educational resources for Faculty of Medicine leadership and medical educators to update the deontology (medical ethics) curriculum. The overall objective was to improve UHS students' knowledge and attitude towards deontology. The

Prepared by Dr Chhim Sarath, DPH MSc MDS, research fellow in the Health Unit, with researchers from the University of Health Sciences. This project was funded by GlaxoSmithKline (Cambodia) Co., Ltd. Citation: Chim Sarath. 2018. "Perception of Medical Professionalism at the University of Health Sciences, Cambodia." *Cambodia Development Review* 22 (1): 1–6.

## In this Issue

specific objectives were (1) to assess medical students' knowledge and attitudes towards deontology, and (2) to identify medical lecturers' perceptions and experiences of teaching deontology. This article provides a summary of the research findings, which can be used as educational aid to remind medical students about their obligations towards the population's health.

**Background**

Cambodia has put a lot of effort into various health sector reforms since the mid-1990s. Health system performance and the health status of the population have significantly improved. The country also met or exceeded most of its health-related Millennium Development Goal targets. Having made impressive strides towards universal health coverage and expanding access to essential services, policy focus has now turned to healthcare quality, with more attention paid to medical education and practice.

Aware of declining public confidence in the Cambodian healthcare system, the Ministry of Health has introduced measures designed to improve the quality and increase the accountability of individual practitioners and institutions. Those measures include Health Strategic Plan 3 2016–20 and the Cambodia-WHO Country Cooperation Strategy (WHO 2016). Public spending on health has increased, and a new Royal Decree on Implementation of Medical Profession Law was issued in 2016. The latter represents an important step towards reinforcing good medical practice at a time when some physicians in Cambodia are influenced by financial interests. The Medical Council of Cambodia subsequently developed legislative framework to strengthen the regulation of health professions.

Ethics education at medical school and enforcement of professional ethics by medical governance bodies should ensure proper medical practice and a standard of conduct that maintains public trust and confidence in doctors and healthcare services. But healthcare-seeking behaviour in Cambodia suggests otherwise, with three times as many people choosing the private sector over the public sector (67 percent versus 22 percent) for initial treatment, according to Cambodia Demographic and Health Survey 2014 (NIS 2015).[1] Anecdotal reports suggest that hundreds of thousands of Cambodians seek health screening and treatment, even emergency care, in Thailand, Vietnam or Singapore: 24 percent (336, 000) of outbound Cambodian tourists in 2016 visited Thailand and 30 percent (420, 000) visited Vietnam for medical purposes (AKP 2017 cited in Marady and Huaifu 2017, 2). According to Cambodia-WHO, shortage of well qualified and motivated health workers in both the public and private sectors adds to the challenges of providing acceptable quality of care (WHO 2016, 20).

Practitioners' professionalism forms the basic contract between doctors and society. Cruess (2006, 170) describes this as a social contract where "society's expectations of medicine are the services of the healer, assured competence, altruistic service, morality and integrity, accountability, transparency, objective advice, and promotion of the public good". That there is a marked deviation in the implementation of this contract in Cambodia has become a matter of great concern to medical practitioners, policymakers and especially the public. This underscores the importance and timeliness of our research, the results of which confirm that reviewing and improving the medical ethics in Cambodian medical schools will promote the ethical and professional conduct of medical students and assure a common standard of entry to the profession.

**Concept of medical professionalism**

Professionalism is defined variously in the literature (see, for example, Passi et al. 2010; Tallis 2006), and can be summarised as "the foundation of trust on which the doctor-patient relationship is built" (Ahadi et al. 2015, Abstract) and "in medicine requires the physician to serve the interests of the patient above his or her own self-interest" (ABIM 1995, 5). More specifically, "professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others" (ABIM 1995, 5).

Similar concepts are encompassed in the works of Tallis (2006), Mueller (2009) and the Accreditation Council for Graduate Medical

[1] Based on a sample of 9,656 (7,902 rural, 1,755 urban) ill or injured people seeking treatment.

Table 1: Core attributes of medical professionalism as commonly defined in the literature

| ABIM 1995 | Tallis 2006 | Mueller 2009 | ACGME 2007 | Mueller 2015 |
|---|---|---|---|---|
| • Altruism<br>• Accountability<br>• Excellence<br>• Duty<br>• Honour<br>• Integrity<br>• Respect for others | • Altruism<br>• Excellence<br>• Teamwork<br>• Integrity<br>• Compassion<br>• Continuous improvement | • Altruism<br>• Accountability<br>• Excellence<br>• Integrity<br>• Compassion<br>• Empathy<br>• Sound medical ethics<br>• Effective communication<br>• Clinical competence | • Altruism<br>• Accountability<br>• Excellence<br>• Integrity<br>• Respect<br>• Compassion<br>• Sound ethics<br>• Responsiveness<br>• Sensitive to diversity | • Altruism<br>• Accountability<br>• Excellence<br>• Humanism<br>• Sound medical ethics<br>• Effective communication<br>• Clinical competence |

Education (ACGME 2007),[2] as shown in Table 1. *The Physician Charter*, a joint work of American and European boards of medicine (ABIM, ACP-ASIM and EFIM 2002), established three fundamental principles and 10 professional responsibilities (Table 2). These attributes of medical professionalism have since been validated in various countries across the globe. The American Board of Internal Medicine (ABIM 1995, 6–9) describes seven signs and symptoms of unprofessionalism that weaken the core elements of professionalism (Table 3). ABIM emphasises that these unprofessional or unethical behaviours erode public trust and breach standards for ethical conduct.

In summary, all these elements of medical professionalism are encompassed in Cambodia's Sub-decree on the Code of Medical Ethics (RGC 2003), as well as the Oath of Allegiance of Medical Professionals, which all medical students take before they embark on their studies and all newly qualified Cambodian doctors take on registering as a physician (RGC n.d.).

**Methods and data analyses**

This was a cross-sectional mixed methods study combining qualitative and quantitative data analyses. Qualitative and quantitative data were collected concurrently. The setting for this study was the Faculty of Medicine, UHS, Phnom Penh.

[2] The Accreditation Council for Graduate Medical Education (ACGME) of the US is an independent, not-for-profit, physician-led organisation that sets and monitors the professional educational standards essential in preparing physicians to deliver safe, high-quality medical care to all Americans.

Table 2: The Physician Charter on Medical Professionalism

**Fundamental principles**

1. Primacy of patient welfare
2. Patient autonomy
3. Social justice

**Professional responsibilities**

Commitment to:

1. Professional competence
2. Honesty with patients
3. Patient confidentiality
4. Maintaining appropriate relations with patients
5. Improving quality of care
6. Improving access to care
7. A just distribution of finite resources
8. Scientific knowledge
9. Maintaining trust by managing conflicts of interest
10. Professional responsibilities

Source: Mueller 2015

Table 3: Seven signs and symptoms of unprofessionalism

1. Abuse of power (e.g. bias, sexual harassment, breach of confidentiality)
2. Professional arrogance
3. Greed
4. Misrepresentation (e.g. lying and fraud)
5. Impairment (e.g. mental health)
6. Lack of conscientiousness
7. Conflicts of interest (e.g. self-referral, acceptance of gifts)

Source: ABIM 1995

Data collection took place in December 2017 through to January 2018.

The qualitative component involved in-depth key informant interviews (KIIs) with 23 faculty members including the dean and vice-dean, representatives of the Medical Council of Cambodia, and lecturers in various disciplines spanning gynaecology and obstetrics, medicine, surgery, paediatrics and deontology. The KIIs were designed to capture information about perceptions and experiences of the Cambodian healthcare system and the teaching of deontology at the Faculty of Medicine, UHS.

The quantitative component entailed a cross-sectional survey, which was administered via face-to-face interviews to 110 year-5 students and 126 year-6 students randomly selected from a total of 625 students (319 year-5 and 306 year-6). The year-5 students had not started the deontology course and the year-6 students had completed it. The survey comprised 22 statements designed to capture their level of understanding about medical professionalism using a five-point Likert scale. Participants were asked to indicate their level of agreement or disagreement with each statement using the following ratings: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree and 5 = strongly agree.

The survey questionnaire and interview questions were developed based on a literature review of the core elements of medical professionalism, namely: altruism, communication, commitment to excellence, patient autonomy, duty, beneficence and non-maleficence, accountability, professional responsibility, respect, justice, self-improvement and adaptability. For non-professionalism, we included statements to assess participants' understanding about conflicts of interest.

Thematic analysis was carried out on the KII transcripts to obtain a holistic picture of key informants' responses, perceptions and opinions. Descriptive statistics were generated from the survey data to describe students' characteristics and to identify the frequency and distribution of responses. The chi-square test was used to determine whether or not differences, if any, in the distribution of responses between year-5 and year-6 students were significant.

**The findings**

***Students' understanding of medical ethics***

When asked about their preferred work setting, 95 percent of the surveyed students would rather work in a clinical hospital environment than in public health or healthcare management. Similarly, 95 percent of them would rather work in the public sector than the private sector. Year-5 and year-6 students showed a similar level of understanding.

Table 4 gives the distribution of total mean scores for all 22 responses, which range between 77 and 107 (compared to minimum-maximum values of 22 to 110). The sums of the ratings of 25 percent of all students lie between 77 and 88, indicating a somewhat negative to neutral attitude towards professionalism, while those of 50 percent of students fall between 89 and 97, indicating a somewhat positive attitude towards professionalism.

Table 4: Distribution of total mean scores for 22 responses

| | Percentile (%) | | | | | Mean (SD) |
|---|---|---|---|---|---|---|
| | Minimum | 25 | 50 | 75 | Maximum | |
| Average rating | 77 | 88 | 93 | 97 | 107 | 92.37 (6.68) |

Note: SD=standard deviation.

Sixteen (73 percent) of the 22 statements covered the attributes of altruism, respect, accountability and duty, patient autonomy, communication and commitment to excellence. The mean scores of 4.00 to 4.98 (out of 5) for those statements indicate high to very high levels of understanding among the students. In contrast, the mean scores of 3.1 for the statement "doctors must not harm patients" and 2.71 for "students must recognise the limits of their competence" point to low levels of understanding. The lowest mean score of 2.46 goes to conflict of interest. Students' ratings of the last three items suggest the potential for unprofessional behaviour.

Specifically, 54 percent of the survey respondents either agreed or strongly agreed that "medical students, during their medical placement, must perform everything that the supervising doctor asks them to do". This suggests they might carry out procedures that they have not been trained to do. In short, they were not aware of the importance of knowing and working within the limits of their competence and informing supervising doctors

of their level of competence. Seventeen percent either agreed or strongly agreed that "doctors should not accept any mistakes or errors reported by nurses and midwives". These students have not fully understood what commitment to excellence means in practice. Twelve percent either agreed or strongly agreed that "health professionals need continual reminders from both peers and supervisors about fulfilling responsibilities to patients and to other healthcare professionals". This means that they do not fully recognise the behaviour and responsibilities expected of them as a professional.

We found no significant differences in the distribution of responses of year-5 and year-6 students. This suggests that students learn and absorb professional and nonprofessional behaviours by observing the practices of medical practitioners in clinics and hospital wards. The lessons students learn from this so-called hidden curriculum are by nature obscure and difficult to qualify.

***Lecturers' perceptions***

Findings from some of the KIIs suggest that most students are not especially interested in deontology. This is because they think of it as an abstract field, rather than as integral to clinical practice. They therefore do not take deontology instruction seriously, instead studying pre-answered multiple-choice questions (MCQs). In addition, the limited number of MCQs and the late introduction of deontology in semester 2 year 5 lead to gaps in students' knowledge of medical ethics, leaving them susceptible to copying unethical practices during their medical placements.

Interviewees gave a variety reasons for students' apparent disinterest in deontology. They are, in no particular order: lecturing is the sole teaching method, students can pass the subject without going to lectures, some students believe the topic is not relevant to curing diseases, UHS does not prioritise deontology, weak disciplinary action for skipping deontology lectures, and students do just enough to get a pass mark.

The KIIs did not capture a clear picture of some aspects of unprofessionalism. Regarding conflicts of interest, some lecturers said that doctors can accept gifts and donations (e.g. cash, food, desserts, fruits and drinks) that are voluntarily given by patients or their families in exchange for services provided by hospital staff. They perceived this is as synonymous with the Cambodian "culture of giving".

**Conclusion**

The majority of the surveyed year-5 and year-6 medical students at UHS have a rough understanding of the concept and practice of medical professionalism. The four areas that scored lower in both years were preventable harm to patients; poor rapport with patients and their families; unmet professional responsibilities; and resistance to constructive criticism, counter to the principle of self-improvement and adaptability.

The findings illumined some misunderstanding among students and medical educators about the concept of conflict of interest. Gifts from pharmaceutical companies to healthcare providers and informal payments in public facilities were considered normal and acceptable, rather than a breach of professional ethics. Such conflicts of interest can damage physicians' reputation and public trust in healthcare services and should be strongly discouraged. Refocussing commitment to ethical behaviour would help repair public trust in the medical profession.

Perhaps the most alarming finding was that most students rated preventable errors that could result in patient harm as normal and acceptable. This implies that as future doctors, they may have an inappropriate high risk-taking propensity, especially if ethical boundaries are blurred by conflicts of interest, and could possibly cause harm to patients. In principle, interactions between physicians and patients should not compromise patient care or exploit vulnerable patients.

The majority of the students exhibited lack of effort towards self-improvement and adaptability, mainly because they were unaware of their inadequacies. In principle, medical students must be able to recognise and work within the limits of their competence. Failure to do so indicates unmet professional responsibilities, meaning students do not meet the standards of professional behaviour expected of them.

An underlying confounding issue is that students appear to learn a lot from hidden informal curriculum, which most probably plays an important role in reinforcing behaviours and attitudes towards professionalism. This suggests that the way deontology is taught needs to be reviewed in order

for students to actively attend the entire deontology course and gain a thorough grounding in medical ethics. Students' acquisition of the attributes of good medical practice will be enhanced if the hidden curriculum they learn from during their medical placements is better understood and incorporated into the formal curriculum.

In sum, medical educators need to rethink training routes and student-teacher relationships. One way forward would be to switch from a teacher-centred to a student-centered approach through more interpersonal interactions in teacher-student relationships, using students' experience as the starting point. Ideally, all doctors and other health personnel in hospitals should be good role models as they have a special responsibility for instilling the principles of good medical practice in the students and young doctors under their supervision.

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