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Challenges in practicing and inculcating professionalism in the University of Nairobi: A mixed methods study

Daniel Ojuka Kinyuru, Joyce M Olenja, Yang B Eunbae and Mwangombe J Nimrod

Corresponding author: Daniel Kinyuru Ojuka danielojuka@gmail.com

Department: Department of surgery, P.O.Box 19676-00202-Nairobi.

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Abstract

Background: Professionalism in medicine is a social contract between society and the medical personnel. Challenges in the practice has been raised worldwide. Since it concerns values that change from time to time and from culture to culture, the concern and challenges are expected to be difference from culture to culture. Our aim was to explore the challenges to inculcation and practice of professionalism as viewed by those who are involved in the surgical teaching environment in Kenya.
Methodology: A sequential mixed methods study was conducted among faculty, registrars, medical students and auxiliary clinical staff at University of Nairobi Department of Surgery, Kenyatta National Hospital surgical wards. The data were collected through focus group discussions and individual interviews, then analyzed using grounded theory. Views expressed were used to construct a questionnaire used in the survey for validation of the challenges mentioned. The survey was analysed using Statistical Package for Social Sciences (SPSS) version 20(Chicago, Illinois)
Results: The majority of the participants felt that the most challenging issue was character as reflected in the poor attitude towards patient and lack of resources that makes it difficult to give professional services. This then leads to the physicians participating more in private practice leading unavailability in the employment place. The two challenges were then confirmed in the survey with 85.1% and 85.6% agreeing respectively.
Conclusion: The predominant challenges according to the view of those in the surgical community in the setting of University of Nairobi in so far as professionalism is concerned are character and financial resources. An appreciation of these challenges should lead to changes in the curriculum and practical changes to the teaching and practice environment.

Keywords: Professionalism

Article

Introduction

Professionalism in the practice of medicine has become a subject of great concern to the public, to those who teach medicine and to practicing physicians (1).

In the Kenyan context, a number of articles that appeared in Kenyan newspapers (2,3). The articles mentioned a doctor who apparently was paid by a member of parliament to forcefully take HIV aids test. The other is a doctor who left a patient on the table with an unsutured surgical wound and went to drink. Regrettably, such stories are not unique. It is appreciated that lack of professionalism is widespread and takes many pernicious forms, ultimately damaging patients' interests and the trust the populace places in the medical services. In literature, the underlying issues that might cause such challenges include : admission of candidates based on academic excellence with no or little relation to attitude and aptitude of the student, commercialization of medical education and services, third-party involvement in management of medical care, reduction of time with patient through technology, loss of supervision and lack of mentoring as well as a reward system which looks more at academic work rather than aptitude (4–6).
Professionalism being value and culture based behaviour, the underlying issues that bring challenges both in teaching and practice environment would differ from culture to culture. The studies outside have been either on students alone or expert in reviews, this study was a qualitative interview that included the regulatory body for the doctors that was validated through a survey within the same environment. This study sought to explore the challenges that are viewed from our context.

Methodology

Setting and population

University of Nairobi is the oldest and largest health professional training institution in Kenya which offers training in a variety of health care disciplines to about 1500 students through 6 undergraduate and 18 postgraduate programs annually. Until 7 years ago, it had been the only institution in Kenya that trains surgeons. The staff establishment as of 2015 for the department of surgery is 12 professors, 4 senior lecturers, 17 lecturers and 7 tutorial fellows comprising subspecialties of general surgery, otorhinolaryngology, neurosurgery, plastic surgery, cardiothoracic surgery and paediatric surgery . The main clinical training site is Kenyatta National and Referral Hospital which provides additional clinical teaching staff; however, staff-to-student ratios remain inadequate because of increased number of medical students admitted in the undergraduate course. The department of surgery teaches undergraduates of the 5-year Bachelor of Medicine and Surgery (MBChB), at their 3rd and fifth year of study. They also teach 3rd year of the Bachelor of Dental Surgery (BDS) as a service provider. The postgraduate class is about 45 students from year postgraduate year PGY2 to PGY 5. The curricula of these programs are still the traditional lecture-based model with clinical rotations in the surgical wards and electives. The surgical wards and main theatres are further staffed with nursing officers, nutritionists, physiotherapists and occupational therapists. These groups together make up the education community from which the student learn. The University of Nairobi was the only university teaching medicine for sometimes and majority of medical doctors who are in Kenya went through its systems, the character influence of the medical field in Kenya is therefore widespread.

The study was conducted within the department of surgery, University of Nairobi and Surgical wards, Kenyatta National Hospital. The study population included consultants, registrars, medical students, nurses, physiotherapists, occupational therapists, nutritionists and medical practitioners and dentist board (MPDB--the regulatory body of doctors and dentists)

Study design

This was a sequential mixed method comprised of qualitative then quantitative survey among the surgical teaching community of the University of Nairobi. The reason for the design is because a precise definition of medical professionalism is value and culture based and the attributes are not universal. Cultural attributes can be difficult to assess using quantitative methods. Qualitative methods may not be generalised since because the informants are not chosen at random and may not be representative. The qualitative part provided in-depth insights into the relevant phenomena. These insights then informed the quantitative part's questionnaires constructed subsequently. I therefore sought the views first then went to verify those views with a survey within the same environment.

Sampling, data collection and analysis

I used purposive sampling for the qualitative arm both for the focus group discussion of 10-12 participants and key informant interview with senior faculty who had been in the department for over 20 years and Medical practitioners and dentist board (MPDB) legal representative. I used grounded theory method of data analysis the qualitative arm with the guiding question for clinicians being, "In your view, what are the main challenges of the teaching and practice of professionalism in your context?" while the MPDB were asked "what are the most frequent challenges that lead to complaints against the surgical doctors in Kenya?" The interviews were audiotaped except in one occasion during key informant interview with a senior faculty earlier on when field notes were used because of technical issues. The principal investigator facilitated the interviews while the assistant recorded using Sony ICD BX112 2GB, the events and notes except in key informant interviews where the principal researcher was alone. The records were transcribed, coded and entered into Atlas 5.2.0 by an assistant. The codes were discussed repeatedly between the assistant and the principal researcher and adjusted when agreed to be appropriate. The collection through the interviews was done till saturation was perceived to have been reached. After saturation I codified the themes from the interviews.

The findings were then employed in the construction of a questionnaire, which was then piloted among five faculty members. After the revision of the questionnaire, it was subsequently distributed to the senior faculty, junior faculty, registrars, medical students, nurses, physiotherapists, occupational therapists, nutritionists. It was distributed to everyone in the faculty through the secretary of the department. Thirteen items concerning challenges in practicing and inculcating professionalism were detailed. For each item the question was: "Most challenging issues in the practice or teaching of professionalism among the surgeons /trainees in the University of Nairobi (UON)?" Informants responded on a 4-point Likert scale: strongly agree (4), agree (3), disagree (2), strongly disagree (1) as demonstrated in appendix 1.

The findings were entered into SPPS version 20 for analysis. Descriptive statistics were used to analyse responses from the survey to identify measures of central tendency for each main domain. Internal consistency reliability was determined by employing Cronbach's α. Chi-square was used for correlation with independent factors such age, role in training of surgery, gender and number of years in the institution.

Results

During the duration of the study, there were 16 focus groups (9 with medical students, 2 with faculty, 2 with nurses, physiotherapists, occupational therapists and nutritionists and 3 with registrars)for discussion each with 10-12 and 11 key informant interviews(10 with senior faculty and 1 with legal representative of the medical practitioners and dentists board.
The analysis of the views through coding demonstrated about 10 themes with various mention through the interview; poor attitude or character(136 times), lack of proper mentorship(69), inadequate and disjointed formal teaching and assessment(49), the institutional culture does not support professionalism(13), no disciplinary measures against those who err(32), inadequate remuneration (77), lack of resources (45), problem of increased work load due to few clinicians compared to patients(25) and students(21) and lack of proper and clear communication between colleagues and with patients. These were further coded into three main themes; character of the health care provider, the institutional factors and inadequate resources.

Character of the health care provider

The majority of participant felt that the main challenge to the practice and instilling of professionalism is the character of the health care providers. This is often seen in the character of the individuals. These attitudes are seen in the way providers view and interact with patients who come to the public hospital.It is also seen in the way the surgeons are not able to avail themselves to the patient postoperatively. The attitude affects the health care workers availability, accountability and responsibility and it speaks of character.

"*The challenges are; lack of availability, irresponsibility, lack of accountability -- all those are the things that make talks about character"* Key informant interview senior faculty.

The character shows in the way the doctors interact with patients and with the students
"You are employed here to be here from morning to evening, you have a duty rota, you have contact time on your daily schedule, there are times when you are not supposed to be anywhere in particular, you have times you have said you want to see students, they come they find you are not here, you are on call this week and they can't find you in the ward, how can you teach professionalism when you are not doing professional practice. There is a disconnect between knowledge and practice" Key informant interview senior faculty.

There are times when there is a mixture of character that depicts the care giver or the teacher as just in need of fiscal prosperity above all else.
"The lecturer has told the student that once she was to go for a class to teach but then there was a call from a certain hospital to go and do a specific surgery which she liked so she chose to go there than to teach" FGD fifth years.

When this is done again and again, it becomes a habit and part and parcel of the institutions culture, it perpetuates corrupt morals.

"We are just used to corruption everywhere wherever you go, it's really not a big deal and it translates into everywhere in the hospital, we do not take anything seriously whether it is financial controls or emergency procedure , and it affects everyone; nurses , cleaners , theatre staff and doctors" FGD fifth year.

It affects the way we communicate with patient as well with colleagues

"*They don't have the time or ability, you know, to sit and listen to you. Some also don't have the ability to listen to the patient, and to be patient and explain to them their story, some people are short tempered; they get annoyed over small things"* FGD Fifth years.

The key informant interview with the Medical Practitioners and Dentists Board representative reveals communication with the patient to be the main problem
"*Most of the things which cause patient complain are basically a lack of communication between the medical personnel the patients, because from what we can see, if medical personnel from doctors to nurses, take a bit of time to explain to them what they are doing, what kind of treatment they are prescribing, some of these cases would not be here"* Key informant interview, *MPDB.*

The explanation was that patients are now having information access and may know what ought to be done, hence increased complaint to the board about doctors. The average number of complaints was 56-70 in a year and there a trend of increase.

"*There is now information access, there is google, somebody has already googled the treatment they are supposed to get, then they go to a doctor, and the treatment they get they say, No, it is supposed to be this", Key informant interview MPDB(board)*

The average complain in a year would be 56 though sometimes it goes to 70 according to the legal representative of the board but a trend of increase has been noted from 2010 because of the constitution and increased literacy.

The search for financial resources makes doctors behave in unprofessional way and that is seen at times in the teaching environment hence will be perpetuated outside.

"A common challenge to practice professionalism in our country is greed, because you want to get monetary gains so you set aside everything else that you think you should be doing right and you go for shortcuts that influence you." FGD Registrars

Mentorship or modeling may be affected also by the very large student population

"*Main challenge in training is that when you look at the medical profession it's* an *apprenticeship which requires contact between the mentee and the teacher so when you have scenario where you see a lectures maybe once or twice a week for the practical sessions not for the class lectures, you have 19 other students competing for that contact with the instructor then it becomes very hard for you to pick up those skills which you need to learn to integrate into your practice"* FGD fifth year.

Some of the challenges are perpetuated because of lack of discipline and accountability by the lecturers
"I think that maybe I am the third or the fourth generation, but I think some of the people, especially the second generation have gotten away with murder in quotes, they don't show up to work, and nothing happens, their work is not audited, now if there is no effort to enforce discipline if somebody shows up at work drunk, and nothing happens to him, not just here in this hospital but even in the district hospitals they don't happen because there is no disciplinary way of approaching everything, and that is enforced. If we brought back the element of discipline I think professionalism will be restored…." FGD Faculty.

When discipline is not there, the negative expressions of professionalism by the faculty and other practitioners become the normative expression.
"Just one sentence accountability, say a very senior person signs a document and says cutting time is this time and it is dated. Several months later no one does anything, another colleague is shouting at another colleague calling names during ward rounds. Everyone knows about this colleague even the other senior colleague knows about this colleague and they are doing nothing about it. Some things will never change…"FGD Faculty.

Institutional factors
The environment under which we practice is one that has many limitations, both in fiscal resources and in institutional cultures that looks for quality.
"We are working in a system where it is impossible to be a professional, as much as we still see patients, I think it is really amazing that they survive because if you go to surgical room in accident and emergency, it is dirty and congested, when we continue working in such environment then we are actually perpetuating unprofessionalism because if we put our feet down and say no we cannot work like this then maybe things can change "FGD Registrars.

Increased workload in terms of patients and sometimes because one is working in more than one hospital can make being professional difficult due to burnout.
"Picture yourself in a situation where there is no morale to work you have so many patients a few doctors you are working so many shifts in a week you are sleeping very few hours in a week you are tired you are fatigues and you are still expected to actually be professional with each and every single patients, it's very difficult as a human being practically speaking I would find that difficult and I think that what happens with most of the junior doctors and senior like the registrars when they are also moonlighting , moving from one hospital to another" FGD Fifth years.

Sometimes it is societal and peer pressure driven of what they should have in terms of materials things making doctors to look for more money in order to be able to survive.
"*There is the mentality of survival then there is also the pressure out there, what the society is looking at like this is a doctor they shouldn't be driving such a car, they should have such a car"* FGD Registrars
"So our society values money more than helping others" FGD Fifth years
"that's why a doctor will open someone's abdomen and do something that is not warranted because he wants to buy a house somewhere" FGD faculty.

The societal expectation for the socioeconomic status of the doctor, the need for more money has resulted in to a situation where supervision, mentorship and modelling are very difficult or nonexistent.
"At the end of the day, the people teaching at the university should be able to mentor but unfortunately we don't have people who can do mentorship, we are all like children, we pick everything, most things by what we see people doing. If we preach water and drink wine, I most likely would ignore what you said and do what I think is right. "FGD Registrars

"We may have the mentors but you find that there is no time that they're available to mentor you because you have a class from 10am to 11am or they're not there like can give an example I had a mentor and I went to the office like 5times and I couldn't find him" FGD Third years

The process of employing lecturers and picking students for either undergraduate or postgraduate education seem to look for only the academic and not the character or the aptitude of the candidate and this ends up making it difficult to train or be trained in professionalism

"*I think when the university is choosing the members of faculty, they should have criteria, I think most of the time it usually academic, if I am an academic giant I could be a lecturer, but it doesn't mean I will be able to transfer my skills to the students in the right way. So there should be other criteria apart from the academic prowess"* FGD Faculty

*"I think where we fail is when straight from high school people just because of the grades you got you are told you go do medicine. I think we should be having interviews for students and ask these questions like why do you want to become a doctor, make that very clear. If it's about passion, not about the money and judge them on that. It shouldn't be about the grades only….."*FGD fifth year

Furthermore, there is no emphasis on the aspect of professionalism, the emphasis is mainly on academic knowledge:
"The syllabus mainly concentrates on the academics, knowledge and skills, and we loose on other issues, social aspects that actually we cannot look at a professional without the professional being part of a social setup, and having an acceptable social behavior " FGD Faculty
Lack of formal teaching and definition of terms means you have different views with no common values or terms which then challenges role modelling since everyone does what they deem fit.

"We have not defined professionalism, we have not contextualized professionalism, even if you are among our seniors or our peers, what professionalism means is totally different, the way they engage here or out is very different and sometimes you can find one senior who has contrary opinion to another not in terms of management. Conduct is not defined, so you pick what you think right, so depending on whom you are dealing with you have to be so called politically correct, if so and so likes this, when you deal with her, it is not defined, no standard, no protocols of engagement…"FGD Registrars

Inadequate resources

It is an environment where there are inadequate resources in terms of human and material resources that makes it difficult for doctors to perform their core duty and therefore get disillusioned.
"There is a challenge to be professional in a setting that is not professional if you don't have what you need to do what you need to do it also hard for you to be a professional, there are no curtains, there are no gloves, the beds are not enough, there are three patients on the bed. You can't be professional in a setting that is really not professional" FGD Faculty
*"You come to theatre , you are informed there is no instrument, list is cancelled, the next time again … then you will want to be in place you can practice…*Key informant Senior Faculty

The views were then coded for the questionnaire into 13 views that were then tested in the survey (Table 1).

Out of the 240 questionnaires send out, 180 were filled and returned with distribution by occupation shown in Figure 1 with a mean age of 31.1 +/-9.6 years with a male to female ratio of 1.6:1

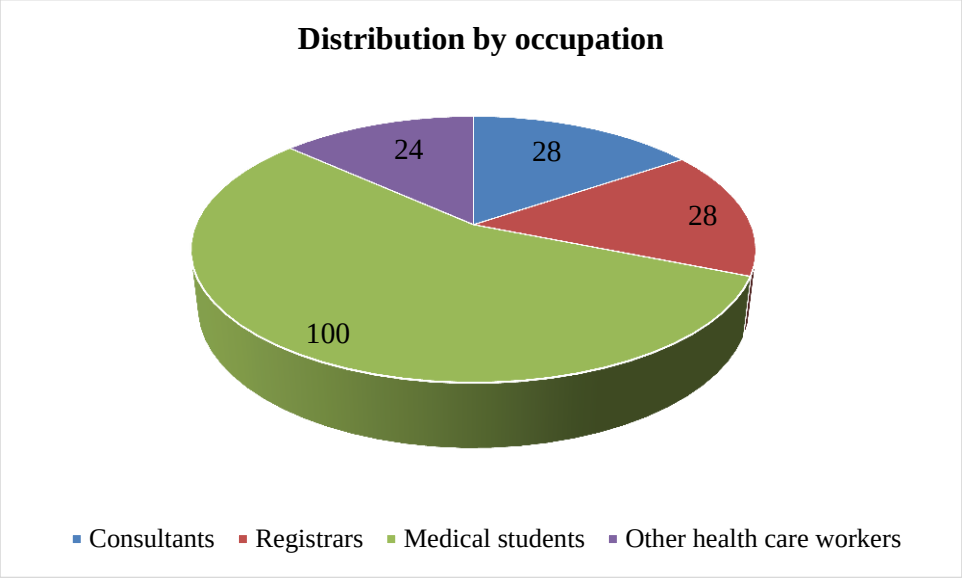

Figure 1: Distribution by occupation

From the qualitative aspects, the respondent were of the view that the serious challenge to the practice and inculcation of professionalism in our environment includes the character and attitude of the health care giver and lack of financial and human resources. They were critical of the lack of role models who would mentor students as well as perceived lack of disciplinary measures for those who err among other issues.
The issues that the participant thought was most important challenging was inadequate resources (54.4% strongly agree) and the least challenge was abiding with regulation (6.1% strongly agree) Table 1

Table 1: Survey items and frequencies

Item	Strongly agree (%)	Agree (%)	Disagree (%)	Strongly disagree (%)	Mean
Inadequate resources	**54.4**	32.8	12.2	0.6	3.41
Character of the individual	**41.1**	47.8	10	1.1	3.29
Motivation by money	**23.9**	39.4	30	6.7	2.81
No recognition of work done by doctor's	**21.7**	40.6	32.2	5.6	2.78
Culture of respect for the rich	20	30.6	45	4.4	2.66
Disillusionment of faculty and student's	18.9	50	28.3	2.8	2.85
Culture of impunity in the society at large	17.8	37.8	39.4	5	2.68
Personal interest overruns patient's interest	17.8	45.6	31.7	5	2.76
Lack of commitment to one's work	17.2	50.6	27.8	4.4	2.81
No institutional culture	15.6	38.9	35.6	10	2.6
Lack of formal teaching	15.6	35	38.9	10.6	2.56
Poor relation with colleagues	12.8	45	36.7	5.6	2.65
Faculty not abiding by regulation	6.1	28.3	55.5	10.6	2.3

The exploration of the 16 items, we performed factors analysis and promax rotation, the Kaiser-Meyer-Oklin Bartlett was 0.856 with a p value of 0.000. The reliability test among the items showed a Cronbach's α of 0.866. Only 3 factors had Eigen values greater than 1.
There was no significant relationship with age, gender, occupation, and number of years one has been in the institution.

Factor analysis resulted in 3 factors, which accounted for 58.2% of the variance most of which was accounted for by factor 1(39.4%) The loading of items indicated the following factor structure.Factor1

(Difficult Institutional environment), Disillusionment of faculty and students, culture of respect for the rich, culture of impunity in the society at large, personal interest overruns patient's interest, no institutional culture that promotes professionalism, lack of formal teaching ,no recognition of work done by doctor's, poor relation with colleagues. Factors 2(Individual character) Character of the individual, motivation by money, lack of commitment to one's work, faculty not abiding by regulation. Factor 3(Inadequate resources easier) inadequate resources (Table 2).

Table 2: **Factor loading, Eigen values and percentage variance of the 3 factors loaded by fifteen items on fostering professionalism**

	Factor 1	Factor 2	Factor 3
Character of the individual		0.329	
Motivation by money		0.795	
Lack of commitment to one's work		0.736	
Faculty not abiding by regulation		0.691	
Inadequate resources			0.667
Disillusionment of faculty and student's	0.560		
Culture of respect for the rich	0.688		
Culture of impunity in the society at large	0.773		
Personal interest overruns patient's interest	0.704		
No institutional culture that promotes professionalism	0.782		
Lack of formal teaching	0.838		
No recognition of work done by doctor's	0.628		
Poor relation with colleagues	0.704		
Eigen Value	5.1	1.3	1.1
% Variance	39.4	10.1	8.7
Cumulative % variance	39.4	49.5	58.2

Discussion

Inculcation of professional values in trainees and its sustenance in practice requires a culture that enables it and where positive modelling is routinely practiced. One of the major threat to the teaching and practice of professionalism today is the disintegration of the education communities which then will hinder transmission of values and behaviours(6).

This study reveals that at the core of challenges is character or the attitude of the individual. This was mentioned a number of times in many ways by the focus group and key informant interviewees and confirmed in the survey performed. Many reviews that have been done demonstrate that most often there will be a character issue that manifests in surgical community in terms of abusive surgeons(4,7). The reports from Uganda (8)indicate students receive much verbal abuse (8). Furthermore the communication by Whitmore during a conference of program directors as the chair indicates that the environment that copes with increased work load, reduced reimbursement and high liability rates will encourage unprofessional physician behaviour(7). The same issues have been raised in this study where doctors moonlight for purposes of increasing their take-home money, therefore making them overworked.

The only difference is that ours was a study; but secondly the work load in our case is due to multiple work sites. The curious thing is that character itself has been mentioned as the main base where the other "excuses" can be given as reasons, one of which is that of personality and regional differences . In a study by Chandratilake et al.(9), there was evidence of geographical and regional variation in attitude, beliefs that constitute professionalism and this might also explain the main finding in our environment that shows our

attitude or character flaw with regard to patients in difference practice set ups. The results suggest that most physicians in the education community will treat a patient in private practice better than they would in the public sector in all areas that defines what professionalism is (7)
Culture has an influence on the personality of an individual, (10) and this will affect their emotions, cognition , motivation and. This may seem to affect the way physicians behave since they feel no responsibility in a collectivistic society, they would rather not go against what others are doing even, they are influenced by the behaviour of others rather than consistency in the arguments(10). It therefore goes without say that what other do, good or bad trickles to everyone. Personal growth and self-esteem is not something that is seen in collectivistic cultures(10).

Poor resource set up is bound to have a major impact on how ethical practice in the light of the current evidence based surgery is being performed. A study in a similar setting in Uganda's Makerere University revealed similar results where there was even a suggestion that developed-nation practice standard should not be similar to developing-nation standards when it comes to practice of professionalism(8). Professionals will feel they require better resources to practice. Although standards of medical care would generally be lower in developing nations than in very affluent nations, still the personal, moral qualities of health professionals could be held to similar standards in both set ups.

The reason for complaint from patients as stated by the MPDB legal representative is mainly how the health care workers communicate to the patient. We have seen from the interview that this at times depends on the socio-economic status of the patient and which clinical care setting the patient is seen by the physician. Much litigation has been reported, not from lack of technical skills, but from lack of professionalism (9). Many physicians seem not to have taken into account that the education level and informational needs of the populace may be changing in a digital age.

For surgeons in particular, technological innovations have meant the improvement of the quality of care. This is measured in reduced hospital stays, faster return to work, and increased economic output. These improvements, in turn, have increased patients' expectations for the outcomes of surgical care. However, these expectations have not always been met. The consequence has been the production of more machines and innovations. At times, this leads to the doctor spending more time with machines than with the patient. With the reduction in contact with patients, concern may shift from the patient as a human being to the surgeon's outcome. This leads to reduced empathy. The good outcomes have seen the development of technological centres. However, their aim is profit, which easily conflicts with altruism as the core of professionalism. This, combined with the increased demand for training, increases the trainee to trainer ratio, making the apprenticeship model difficult to achieve (11).

The Flexner's model of clinician- teacher-researcher, where each would generate income from his or her work and putting the personal interest aside (12) is difficult to achieve as illustrated by the findings in the result section. The teacher has to moonlight as well as the trainee, meaning very little time in academic work for both. This further illustrates the effect of commercialization of the medical care, where it is seen as the source of income rather than a gift to help alleviate suffering as the Prayer of Maimonides states "in suffering let me see only human being"(13) . Commercialization means the teacher has less time to teach (14) but also in our context that those who cannot afford or from low socioeconomic status get less time of the doctor and poor service since they may not even afford litigation fee some suggested in this study.

The forces of commercialization have affected our medical education as well. Surgery, being a practical field, suffers the most. The training of doctors is no longer seen as a calling to help alleviate human suffering, but primarily as a way to earn a living. A doctor's nobility was based on the fact that he put the interests of others before his own, but in the current context it is based on his income and lifestyle. This study reveals that the personal interest of the doctors overrides that of the patient as was agreed by 59.6% of the participant in the survey and revealed by the numerous interviews of the participants. These circumstances are not unique to the prevailing context. Even in the earlier days of medicine, these influences were present. Hence the lamentation by Richard Steele (1672-1729) that "a doctor who can help a poor man and will not do so without a fee, has less sense of humanity than a poor ruffian who robs a rich man to supply his necessities. It is something

monstrous to consider a man of liberal education tearing the bowels of a poor family by taking for a visit – as fee – what would keep them for a week"(11).

Two types of doctor-patient relationships were described by Plato. In the first one, commercial based, where the patient is treated without taking time to listen to him, they are treated empirically, for money. In the second one, the doctor would listen, would not treat his patient until he had earned his trust, and would only then persuade the patient to comply(11). Our set up seems to suggest that the money patients are listened to while those without money are not listened to at all.

When learning takes place in an environment where the trainer is extremely busy because he has to attend to his clients much of the time, the students learn that health care as a business is more important than health care as a calling. In our current context, students are taught by trainers who spend limited time with patients in public hospitals due to low pay by the university and government. This only drives the point home(15) .

Hafferty has referred to the commercialization of the medical profession as "the elephant in the room of medical education" in an eponymous review of professionalism. Within the review, he recounts how medical care has been turned into a business by entrepreneurs, and how investors in the pharmaceutical industry use doctors by paying them to market their products. This erodes the autonomy of the doctors and of their decisions, which should be based, not on their income, but on scientific evidence (16). He advocates for peer review and for responsibilities at the societal level. In other words, he calls for the community of physicians to take the responsibility to protect, nurture, and expand the role of the physician in order to maintain the values and ideals of professionalism against the prevailing social forces of the free market and bureaucracy (16).This is seen in our set up in the way the physicians are keen to work and moonlight in the private sector at the expense of learning and of the care of the patient.

The recognition of the doctor's work, mainly by the way of the remuneration as well as the general society that seem to recognize those who prosper is not good. Lack of recognition of the clinical work of doctors has been shown to be a major challenge for those who want to concentrate on caring for the patient (13,17) because in some institutions , publication and research form part of what administration uses for promotion of personnel. This is the same in our set up though the recognition talked of in our study was more of the societal recognition as well as remuneration.

In conclusion, this study find that the major challenges in inculcation of professionalism in our set up is to with the character flaw of the individual and financial resources which is further compounded by the issues such as lack of regulation and personal interest.

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Competing interests

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Corresponding author information

Daniel Kinyuru Ojuka, is a lecturer at the department of surgery, University of Nairobi. Email address is danielojuka@gmail.com Telephone +254722322246

Notes on contributors

Dr Ojuka Kinyuru Daniel [1]
Professor Olenja M Joyce [2]
Professor Eunbae B Yang[3]
Professor Nimrod J Mwangombe[1]

Authors Affiliation

1. Department of surgery, College of health sciences, University of Nairobi
2. School of Public health, college of health sciences University of Nairobi
3. Department of Medical Education, Yonsei University College, South Korea

Author contribution
Design, collection of data, analysis and write up

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Appendix 1

Most challenging issues in the practice or teaching of professionalism among the surgeons /trainees in the UON

Issue	Strongly agree	Agree	Disagree	Strongly disagree
Personality /character of lecturer/ doctor's				
Motivation is money rather than outcome of either patient or student				
Lack of commitment to one's work				
Doctor's don't abide by any regulation, either hospital or university				
Inadequate equipment, office space, payment, workers and lecturer rooms				
Disillusionment of faculty and student's				
Culture of respect for the rich regardless of how they acquired their wealth				
Culture of impunity in the society, no discipline even for those who have errand				
Personal interest overruns patient's interest				
No institutional culture to guide professionalism				
Lack of formal teaching and assessment of professionalism				
No recognition of work done by doctor's				
Poor relation with other health care workers				