



Professionalism and patient-centred care—patients' views and experience

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Background: Doctors' demonstration of professionalism and adoption of a patient-centred care (PCC) approach are two important elements that affect patients' experience and satisfaction of service, influencing the trust between doctors and patients to a certain degree. In the past two decades, the number of medical disputes and violence against doctors has escalated despite the significant changes introduced to the Chinese public hospital system. Studies have tried to clarify the reasons, but there is limited evidence examining inpatient perceptions of medical practice, inpatients' actual experience of the professional practice of doctors and the adoption of patient-centred approaches, in particularly consultation on their preferences.

Methods: The quantitative study collected data via a paper-based questionnaire with multiple choice questions which was distributed to inpatients who had received their discharge notice from two hospitals (Level III and Level II) in Jinan, China. Questions were developed informed by previous studies and discussions with project members. Data were manually double entered into two MS Excel files and underwent error checking before imported into one IBM SPSS version 25 file. Descriptive statistics were performed on all variables. The dependent variables were analysed by independent variables such as hospital, department, gender, residence, age group, education, occupation and annual income by cross tabulation and chi square tests.

Results: A total of 1,183 inpatients discharged from the surgical and medical departments from the two hospitals participated in the survey yielding a 93% response rate. The study confirms that more than 80% of the patients held their doctors in high regard and had a positive experience of the doctor-patient interaction. However, negative responses consistently received from 2–5% of patients should not be ignored.

Conclusions: The paper argues that hospitals should promote a PCC approach fostering patient consultation and support a no-blame culture. An assessment of patient experience linked with quality of care should be incorporated into the ongoing performance review process. A clear legal framework and procedures that protect both patients and doctors in times of medical dispute are required. In addition, medical education and training should include the development of the concepts of 'professionalism' and 'patient-centred care' for future medical practitioners.

Keywords: Chinese public hospitals; doctor-patient relationships; inpatient experience and autonomy; patient-centred care (PCC)

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Introduction

Empirical evidence strongly supports the positive association between patient experience and patient satisfaction, and patient outcomes (1-3). Patients' experience can be influenced by the interaction between patients and doctors and the patient-centred care (PCC) approach (1,4). The world-wide practice of patient centred care shifting from 'doctor-centred' has improved the communication with and engagement of patients in active discussions (5,6), empowering patients to contribute to the decision-making processes (7,8). Evidence suggests that being sensitive and considerate of patients' physical and psychosocial needs, encouraging patients to voice their concerns, and actively involving them in decision-making are the three most consistent elements of PCC (6,9). Healthcare organisations

can enable PCC by establishing a strategic vision to create a culture that enables positive patient experience, developing a supportive environment for employees, investing in systematic measures and feedback to track progress and improvement, and involving patients and their families in designing care provision (10,11).

In practice, trust affects patient-doctor relationships, is a potential barrier to the implementation of a patient-centred approach with subsequent patient satisfaction, and a major reason behind medical disputes (12). Doctors earn patients' trust not only by their clinical expertise and effectiveness, but also by maintaining high standards of moral responsibility, demonstrating respect, compassion, and integrity, by giving patients a sense of autonomy and 0 pt making an effort to understand their experiences, and by communicating clearly and honestly (13). Doctors' willingness to put patients' welfare ahead of all other considerations is equally important (12,14). Such values and professional conduct are the foundation of the professional identity of the medical profession, which needs to be formed throughout medical training and further developed during practice (15). The competence of the medical workforce is one of the keys to the quality and efficiency of hospital service provision with improved patient outcomes which should be assessed by adopting the best evidence-based practice, the delivery of the best clinical outcomes demonstrating high levels of ethical and professional standards.

In China, 37% of all hospitals (n=33,000) are public hospitals that provide 85% of all health services including inpatient and outpatient services. The admission demands of public hospitals have more than doubled since 2005 (16), significantly increased the workload for doctors and waiting times for patients, directly affected doctors and patients interaction and patients' experience of care (17,18). In addition, the current public hospital volume-based funding schemes have pressured hospitals to generate profit to secure the income of staff and encouraged revenue generation behaviours amongst doctors resulting in an increase of out-of-pocket costs for patients (19). Furthermore, the medical curricula in China give little focus on effective interaction with individual patients. The principles of professionalism for medical practice such as prioritising patients' welfare, enabling patient autonomy by involving patients in the decision-making process, and accepting the principles of social equity (20,21) may not have been fully understood and applied to guide clinical practice.

To develop a medical workforce competent in providing

Highlight box

Key findings

- The study found a healthy relationship built between the participants in the study and the doctors who treated them and identified the needs of improving the patient-centred care (PCC) principles to further strengthen the relationships. Strategies to prevent the practice of 'Defensive Medicine' amongst doctors as way of self-protection from potential patient complaints and dispute are required.

What is known and what is new?

- Developing patients' trust toward doctors is fundamental to improving doctor-patient relationship and the prevention of medical disputes.
- The successful adoption of a PCC approach in hospitals not only require doctors' efforts in changing the way how they interact and communicate with patients, but also the development of organizational policy and strategies that support the improvement and transition.
- Positive attitude toward PCC must be developed during the earlier stage of medical education and postgraduate training.

What is the implication, and what should change now?

- Patient-centred culture needs to be developed including incorporating patients' positive experience as part of the performance measure of the hospital and its departments.
- A legal framework with defined procedures that protects both the rights of doctors and patients that incentivise hospitals to develop clear procedures and protocols to guide the implementation of PCC by doctors and other health professionals are required.
- The improvement of the medical curricular and pedagogy focusing on developing a competent medical workforce that can demonstrate high levels of professionalism in their practice with positive interactions with patients is crucial.

Table 1 Inpatient participation by hospital and department

| Hospitals | Target population | Monthly turnover | Questionnaire completion | | |
|-----------|---------------------|------------------|--------------------------|-----------|--------------------|
| | | | Distributed | Completed | Completion rate, % |
| QFSH | Surgical department | 4,400 | 480 | 413 | 86 |
| | Medical department | 4,500 | 553 | 539 | 97 |
| LWH | Surgical department | 397 | 88 | 83 | 94 |
| | Medical department | 583 | 152 | 148 | 97 |

QFSH, Qian FoShan Hospital; LWH, LaiWu Hospital.

high quality healthcare services to patients in Chinese hospitals, an understanding of the professional practice of doctors in the process of providing diagnosis and treatment to patients is necessary. It will identify areas for improvement, inform revision of the medical curricula, and develop organisational strategies to improve professional practice among medical graduates and practitioners. This research answers the following questions:

- (I) What are inpatients' experience of the care provided by their doctors?
- (II) To what extent have doctors demonstrated their professionalism throughout the diagnosis and treatment process?

Methods

A paper-based survey included multiple choice questions was conducted in October 2019, targeting inpatients of the medical and surgical departments of two hospitals at the time of receiving discharge notice. A Level III hospital—Qian FoShan Hospital (QFSH) and a Level II hospital—LaiWu Hospital (LWH) in Shandong Province were chosen. The planned sample size was 10% of the monthly volume of the inpatients at both medical and surgical departments at these hospitals (refer details in *Table 1*).

Hospitals in China are categorised by level. Level III hospitals are large teaching hospitals, usually with more than 500 beds, that provide complex care with research and clinical teaching capacity. Level II hospitals are located in a suburb of a large city or in medium sized cities, and contain more than 100 beds, but less than 500.

Questionnaire

The questions were first developed in the English version informed by previous studies and the results of

the consultation with experts from both hospitals. The English version of the questionnaire was translated into simplified Chinese, then back translated into English by two independent collaborators to maintain accuracy. Minor adjustments were applied to the final Chinese version. The questionnaire was pilot tested by eight inpatients at both hospitals. The questionnaire includes eight questions to collect hospital and sociodemographic data and an additional 20 questions in the following three categories:

- (I) Patients attitudes towards and perceptions of their doctors (9 questions);
- (II) Consultations in relation to tests and treatment (8 questions);
- (III) Professionalism and communications (3 questions).

The questionnaires were completed either by patients or their family members or the nurses who assisted them in the discharge process. Collection boxes were placed at various hospital exits for the return of questionnaires.

Patient recruitment

Four project staff who were registered nurses were recruited to complete the patient recruitment for questionnaire completion. Each of these four staff were positioned at the General/specialised services and Surgical services for 4 weeks in both hospitals. Project staff approached patients who had just received their discharge notice and were waiting for the completion of the relevant paperwork by medical staff and their carers (family members). The project staff provided the patient with the participant information sheet and verbal explanation of the purposes of the survey and what was required. The process generally took 15 min to complete. Upon request, staff may also assist patients in completing the questionnaire. Once completed, project staff would move onto the next patient who just received

the discharge notice. The patient selection process was a complete random process depending on the availability of the project staff at that time the patient was discharged.

Data analysis

Data from the paper-based questionnaires were manually double entered into two MS Excel files and underwent error checking. The data were then imported into one IBM SPSS version 25 file. Descriptive statistics were performed on all variables. The dependent variables were analysed by independent variables such as hospital, department, gender, residence, age group, education, occupation and annual income by cross tabulation and chi square tests.

Ethical statement

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study received ethics approval from La Trobe University (HEC19251, 30 March 2019) and the approval from the Research Committees of QFSH and LWH for conducting the study with their patients as described in the methods section. Information on informed consent was included at the beginning of the paper-based questionnaire. All participants were reminded that implied consent to the study was provided by completing and returning the questionnaires. The anonymous nature of the survey was verbally explained to each of the participants by the project staff and relevant information also included in the participant information sheet. The survey did not collect identifying information to protect participants' anonymity.

Results

Participants, responses and gender

A total of 1,183 out of 1,273 (93%) distributed questionnaires were completed and returned. Details of questionnaire distribution and completion are included in *Table 1*. Amongst the completed questionnaires, 38% were completed by patients themselves, 53.5% were completed with the assistance from family members who were at the hospital at the time of the discharge, and 8.5% (7% of inpatients from QFSH and 1.5% of inpatients from LWH) were completed with the assistance from the nurse on duty. The male:female ratio was close to 1:1 without significant gender differences between inpatients at the two hospitals

and departments.

Place of residence

QFSH is located in Jinan, the capital city of Shandong province and is a Level III tertiary hospital. The majority of its patients are either from locally or referred from Level II and Level I hospitals in or outside the city. Hence, patients at QFSH were more likely to be metropolitan residents (56.3% from metropolitan, 17.9% from regional and 25.8% from rural area) compared to those at LWH a small city in Shandong province (32.7% from metropolitan, 24.3% from regional and 42.9% from rural area) ($\chi^2=44.462$, $df=3$, $P<0.0005$).

Age group

About 33% of the inpatients were between the age of 35 and 54 followed by 18 and 34 (25.1%) and 60 or over (24.8%). Patients at QFSH were more likely to be in the younger age groups than those from LWH ($\chi^2=19.901$, $df=4$, $P=0.001$).

Education

Patients at QFSH tended to have higher levels of education than inpatients from LWH ($\chi^2=46.181$, $df=4$, $P<0.0005$). About 45% of inpatients at QFSH and 23% of inpatients in LWH have acquired a university degree and 10% of inpatients at QFSH and 19% of inpatients at LWH with primary school certificate only or below.

Income and occupation

More patients at QFSH (32%) had higher incomes than inpatients at LWH (9%) ($\chi^2=54.852$, $df=2$, $P<0.0005$). However, the proportion of inpatients in the low-income category was similar between the two hospitals (33% *vs.* 38%). The percent of employed inpatients in LWH is 32% which is significantly higher than the 7% for QFSH ($\chi^2=822.226$, $df=2$, $P<0.0005$).

Group one on 'Patients' attitudes and perceptions' includes nine questions

- ❖ Q1. In the previous diagnostic and treatment process, doctors earned my trust;
- ❖ Q2. During the diagnostic and treatment process,

Table 2 Percentage distribution of responses to Group 1 questions by hospital (differences tested by Chi-square)

| Questions | Hospital | Strongly disagree, % | Disagree, % | Neither A nor D, % | Agree, % | Strongly agree, % | χ^2 | df | P |
|-----------|----------|----------------------|-------------|--------------------|----------|-------------------|----------|----|---------|
| Q1 | QFSH | 1.7 | 1.4 | 8.1 | 24.2 | 64.6 | 22.525 | 4 | <0.0005 |
| | LWH | 0.0 | 0.9 | 5.2 | 13.5 | 80.3 | | | |
| Q2 | QFSH | 3.2 | 2.8 | 11.5 | 20.2 | 62.3 | 19.671 | 4 | 0.001 |
| | LWH | 1.3 | 0.4 | 8.3 | 13.0 | 77.0 | | | |
| Q3 | QFSH | 45.9 | 13.5 | 15.4 | 9.2 | 15.9 | 33.672 | 4 | <0.0005 |
| | LWH | 54.1 | 6.1 | 8.3 | 4.8 | 26.6 | | | |
| Q4 | QFSH | 2.4 | 2.7 | 16.0 | 26.7 | 52.4 | 39.729 | 4 | <0.0005 |
| | LWH | 2.2 | 0.4 | 7.8 | 14.8 | 74.8 | | | |
| Q5 | QFSH | 1.4 | 1.5 | 6.6 | 20.9 | 69.6 | 2.916 | 1 | 0.088 |
| | LWH | 0.0 | 1.3 | 5.2 | 19.6 | 73.9 | | | |
| Q6 | QFSH | 3.1 | 4.2 | 15.5 | 17.0 | 60.3 | 64.934 | 4 | <0.0005 |
| | LWH | 9.1 | 1.3 | 3.0 | 7.0 | 79.6 | | | |
| Q7 | QFSH | 2.0 | 2.7 | 7.6 | 20.1 | 67.6 | 52.967 | 4 | <0.0005 |
| | LWH | 9.2 | 1.7 | 2.2 | 8.7 | 78.2 | | | |
| Q8 | QFSH | 1.4 | 1.4 | 4.9 | 15.7 | 76.6 | 18.218 | 4 | 0.001 |
| | LWH | 0.4 | 0.4 | 6.1 | 6.1 | 87.0 | | | |
| Q9 | QFSH | 6.8 | 6.1 | 34.6 | 22.2 | 30.4 | 19.047 | 4 | 0.001 |
| | LWH | 11.8 | 7.9 | 41.9 | 12.7 | 25.8 | | | |

QFSH, Qian FoShan Hospital; LWH, LaiWu Hospital.

doctors showed the same level of care to each of their patients;

- ❖ Q3. The reason for patients giving gifts to doctors is to receive better diagnosis and medical treatment;
- ❖ Q4. My experience has positively changed my regards for doctors;
- ❖ Q5. The improved medical knowledge of patients has pressured doctors to act more rigorously;
- ❖ Q6. Medical practice is a high-risk profession;
- ❖ Q7. Doctors have heavy workloads and the work that they perform is complex;
- ❖ Q8. Doctor is a profession with high level skill requirements which involves a lengthy process;
- ❖ Q9. Doctors are amongst the high-income group.

A 5-point Likert agreement scale was used. *Table 2* includes percentage distribution of responses amongst all participants and by hospitals, and results of cross-tabulations and chi-square to test the significance of any differences are reported. The perception of answers in each of the point and the testing the statistical differences between two

hospitals in choosing the answer of ‘strongly agree’.

Group two on ‘Consultation related to tests and treatment’ includes eight questions

- ❖ Q10. In your experience, did you think the diagnostic tests required by the doctors were unnecessary?

The question gave the choice of Yes or No. Sixteen percent from QFSH or 11.7% of patients from LWH selected Yes. There were no significant differences in the distribution of responses between hospitals ($\chi^2=2.916$, $df=1$, $P=0.088$).

- ❖ Q11. In your opinion, what is the reason that doctors require patients to undergo unnecessary diagnostic tests?

Three reasons were provided for selection: ‘lack of experience’, ‘generate profit for the hospital’, and ‘doctor self-protection’. The percentage of patients at QFSH selected each of these three answers is 14.4%, 28.5% and 57.1% respectively. For patients at LWH the percentage

Table 3 Percentage distribution of responses for questions 12–17 by hospital (differences tested by Chi-square)

| Questions | Hospital | Strongly disagree, % | Disagree, % | Neither A nor D, % | Agree, % | Strongly agree, % | χ^2 | df | P |
|-----------|----------|----------------------|-------------|--------------------|----------|-------------------|----------|----|---------|
| Q12 | QFSH | 51.0 | 22.1 | 12.6 | 5.8 | 8.5 | 13.904 | 4 | 0.008 |
| | LWH | 60.4 | 12.2 | 10.4 | 6.1 | 10.9 | | | |
| Q13 | QFSH | 5.4 | 7.3 | 8.9 | 19.7 | 58.7 | 33.807 | 4 | <0.0005 |
| | LWH | 1.0 | 1.5 | 3.9 | 33.2 | 60.5 | | | |
| Q14 | QFSH | 2.6 | 4.0 | 8.4 | 23.0 | 62.1 | 23.954 | 4 | <0.0005 |
| | LWH | 0.4 | 1.3 | 5.2 | 14.4 | 78.6 | | | |
| Q15 | QFSH | 2.3 | 3.5 | 14.3 | 23.4 | 56.6 | 34.761 | 4 | <0.0005 |
| | LWH | 2.2 | 0.4 | 11.3 | 10.0 | 76.1 | | | |
| Q16 | QFSH | 2.4 | 3.1 | 11.4 | 23.3 | 59.7 | 27.404 | 4 | <0.0005 |
| | LWH | 1.3 | 1.7 | 13.0 | 9.1 | 74.8 | | | |
| Q17 | QFSH | 2.3 | 1.6 | 9.8 | 24.1 | 62.3 | 20.518 | 4 | <0.0005 |
| | LWH | 0.9 | 1.7 | 5.2 | 14.4 | 77.7 | | | |

QFSH, Qian FoShan Hospital; LWH, LaiWu Hospital.

is 7%, 21.8% and 71.2% respectively. Patients at LWH is more likely to choose ‘doctors’ self-protection’ compared to patients at QFSH, whereas patients from QFSH were more likely to consider ‘lack of experience’ or ‘generate profit for the hospital’ as the reasons ($\chi^2=14.590$, $df=2$, $P=0.001$).

A 5-point Likert agreement scale was provided for the following six questions with the distribution of answers included in *Table 3*.

- ❖ Q12. During the diagnostic and treatment processes, doctors asked me to go through unnecessary examinations and diagnostics tests.
- ❖ Q13. During the diagnostic and treatment process, doctors sought my permission before prescribing tests and diagnostic procedures.
- ❖ Q14. During the diagnostic and treatment process, doctors sought my permission before deciding the treatment plan.
- ❖ Q15. During the diagnostic and treatment process, doctors spent enough time asking me about my condition and symptoms.
- ❖ Q16. During the diagnostic and treatment process, doctors patiently explained the complex diagnosis and treatment process to me.
- ❖ Q17. Based on my own experience or experience of my family members, doctors explained the possibility of adverse outcomes/prognosis that we may encounter

during the diagnosis and treatment process in advance.

Group three on ‘Doctors’ professionalism and communication skills’ includes three questions

- ❖ Q18. During the diagnostic and treatment process, doctors taught me how to maintain health and prevent illness;
- ❖ Q19. Doctors often used medical terms which are hard to understand to explain the condition to me;
- ❖ Q20. During the diagnostic and treatment process, doctors were able to use simple language to explain medical terminology that I could not understand.

A 5-point Likert agreement scale was provided with the distribution of answers included in *Table 4*.

Effect of independent variables on participant responses

The results indicate that ‘hospital’ is a significant factor consistently affecting the distribution of responses between patients from QFSH and LHW in 18/20 questions.

The modifying effect of the other seven independent variables (department, gender, residence, age group, education, occupation and annual income) varied, ranging from infrequent [sex (1 question), annual income (2 questions), residence (3 questions) and department (4 questions)] to moderately frequent [occupation

Table 4 Percentage distribution of responses to questions 18–20 by hospital (differences tested by Chi-square)

| Questions | Hospital | Strongly disagree, % | Disagree, % | Neither A nor D, % | Agree, % | Strongly agree, % | χ^2 | df | P |
|-----------|----------|----------------------|-------------|--------------------|----------|-------------------|----------------------------|----|---------|
| Q18 | QFSH | 2.5 | 4.4 | 11.2 | 23.7 | 58.2 | 33.925 | 4 | <0.0005 |
| | LWH | 0.9 | 1.7 | 9.6 | 10.0 | 77.8 | | | |
| Q19 | QFSH | 36.7 | 31.2 | 15.9 | 6.1 | 10.1 | No significant differences | | |
| | LWH | 43.2 | 26.6 | 13.5 | 7.0 | 9.6 | | | |
| Q20 | QFSH | 2.7 | 4.1 | 8.4 | 24.8 | 60.1 | 24.537 | 4 | <0.0005 |
| | LWH | 1.7 | 2.2 | 9.6 | 11.3 | 75.2 | | | |

QFSH, Qian FoShan Hospital; LWH, LaiWu Hospital.

Table 5 Relationships between independent variables and the number of dependent variables (n=22) they effect

| Variables | Hospital | Department | Sex | Residence | Age group | Education | Occupation | Annual income | No. of independent variables (%) [†] | No. of dependent variables (%) [‡] |
|---------------|----------|------------|-------|-----------|-----------|-----------|------------|---------------|---|---|
| Hospital | | SSD+ | NSSD | SSD+++ | SSD++ | SSD+++ | SSD+++ | SSD+++ | 6 (85.7) | 19 (86.4) |
| Department | SSD+ | | NSSD | NSSD | SSD+++ | NSSD | SSD+++ | NSSD | 3 (42.9) | 4 (18.2) |
| Sex | NSSD | NSSD | | NSSD | SSD++ | SSD++ | NSSD | SSD+ | 3 (42.9) | 1 (4.5) |
| Residence | SSD+++ | NSSD | NSSD | | SSD+++ | SSD+++ | SSD+++ | SSD+++ | 5 (71.4) | 3 (13.6) |
| Age group | SSD++ | SSD+++ | SSD++ | SSD+++ | | SSD+++ | SSD++ | SSD+++ | 7 (100.0) | 9 (40.9) |
| Education | SSD+++ | SSD+++ | SSD++ | SSD+++ | SSD+++ | | SSD+++ | SSD+++ | 7 (100.0) | 8 (36.4) |
| Occupation | SSD+++ | SSD+++ | NSSD | SSD+++ | SSD++ | SSD+++ | | SSD++ | 6 (85.7) | 7 (31.8) |
| Annual income | SS+++ | NSSD | SSD+ | SSD+++ | SSD+++ | SSD+++ | SSD++ | | 6 (85.7) | 2 (9.1) |

[†], the number and percentage of independent variables with which the row variable has a statistically significant different distribution; [‡], the number and percentage of dependent variables whose distributions are significantly different statistically across the subgroups of the row independent variable. NSSD, no statistically significant difference, $P \geq 0.5$; SSD+, statistically significantly difference, $P \geq 0.010$ and < 0.05 ; SSD++, statistically significantly difference, $P \geq 0.001$ and < 0.01 ; SSD+++, statistically significantly difference, $P < 0.001$.

(seven questions), education (8 questions) and age group (9 questions)]. See *Table 5* for more detail.

However, the relationship between the eight independent variables is highly complex (refer to *Table 5*), potentially resulting in multiple confounding and effect modification in the relationships between the independent and dependent variables.

Discussion

Statement of principal findings

The study indicates that most of the patients recognise the complex nature of the work that doctors must perform and show positive attitudes and respect towards them. Doctors'

heavy workloads and the requirements of having high levels of skill to perform complex tasks were broadly recognized by inpatients in both hospitals. This encouraging finding indicates a healthy relationship had been built between the participants in the study and the doctors who treated them. More importantly, the findings were consistent, although often different, between hospitals. However, the study confirms that a small proportion of inpatients questioned the necessity of the services that they received. They also felt that there were inadequate opportunities for consultation during the diagnostic and treatment processes, indicating a service improvement gap. The study also identified the possibility of 'Defensive Medicine' amongst doctors as way of self-protection from potential patient

complaints and dispute.

Strengths and limitations

High participant response rate resulting in views representative of the target population is the main strength. Only seeking subjective opinions and studying two hospitals were two main limitations affecting the validity and generalisability of the results nationally. Although the study might have collected biased information from patients, it will not affect the benefits of the study as it focused on understanding patients' experience and perception that maybe considered for further improving the professional practice of the medical workforce.

Interpretation within the context of the wider literature

Empirical evidence internationally and from previous studies in China indicate that the erosion of trust is one of the major reasons behind medical disputes (12,22). The basis of patient's trust is the confidence that doctors will put their patients' welfare ahead of all other considerations (22). The root cause of any mistrust toward doctors must be addressed to create a positive and consistent inpatient journey. However, the successful adoption of a PCC approach in hospitals cannot rely on doctors' efforts in changing the way how they interact and communicate with patients. Organizational policy and strategies are needed to support the improvement and transition. This may include leadership support, a supportive work environment for clinical staff and systematic measure and feedback etc. (3,8,10). Shifting 'doctor-centeredness' to 'patient centeredness' is about keeping a balance between doctor and patient autonomy. A positive patient journey can be created by taking patients' preferences into consideration and designing care focusing on the needs of the patient as an individual rather than as a disease episode (6,9,23) which should be enabled by both doctors but the organisation.

'Defensive Medicine' can arise because of the unclear legal framework and lack of protection to the medical profession—turning doctors' behaviour into a defensive mode (21,24), such as over-prescribing medical procedures, clinical tests and unnecessary medication, and avoiding risky patients and procedures (25,26). Ultimately, this will further exacerbate the already challenged doctor-patient relationship (12,21). Immediate improvement is unlikely under that current public hospital funding arrangements when financial gain has become one of the key performance.

Indicators of public hospitals. This may also explain why a larger proportion of inpatients had more positive experience of the care in the smaller hospital (LWH) than that of the large tertiary hospital (QFSH) where more complex and expensive care is provided, involving more diagnostic and treatment procedures.

Patient consultation is a critical step to putting patients' preferences into consideration—one of the key principles of professional practice in medicine (14,27). Fifteen percent of the study participants indicated that their doctors did not consult them before determining the diagnostic procedure and treatment and used medical terminology to explain the condition which was hard for patients to understand. These put the hospitals at further risk of patient dispute. Doctors' poor communications and the inability to demonstrate professionalism in medical practice may further deteriorate doctor-patient relationships (16,28). In the challenging Chinese healthcare context with increasing medical disputes and violence against doctors being documented (16), urgent actions to address patient concerns and discontent are required to create a more positive patient experience which is important to improve patient compliance and prevent unnecessary delay in seeking medical care.

In China, the performance appraisal of doctors focuses heavily on qualifications, seniority, publications, research funding/projects, intellectual properties produced that were of commercial value, and awards received. None has direct linkage to interaction with patient, patient experience of care and care outcomes. PCC approach must be enabled at the organisation level and positive attitudes toward PCC must be developed during the earlier stage of medical education and postgraduate training (27). Although significant changes have been introduced to medical education in China as a result of the Chinese Higher Education Reform, establishing clinical competency that meets international standards is still the ultimate and only focus (29,30).

Implication for policy, practice and research

Patient-centred culture needs to be developed including incorporating patients' positive experience as part of the performance measure of the hospital and its different departments. A clear legal framework with defined procedures that protects both the rights of doctors and patients and supports a no-blame culture, and system level policies that incentivise hospitals to develop clear procedures and protocols to guide the implementation of

PCC by doctors and other health professionals are required.

The revision of the medical curricular focusing on developing a competent medical workforce that can demonstrate high levels of professionalism in their practice with positive interactions with patients is crucial. This will improve overall positive patient experience in the care process (24) and quality of care that patient receive.

Conclusions

The study confirms that majority of the patients held their doctors in high regard and had positive experiences of the doctor-patient interaction during their inpatient journey. However, the study indicates required efforts from the hospital to promote an overall positive attitude toward PCC and patient engagement in decision-making. An assessment of patient experience linking with quality of care should be incorporated into the ongoing performance review process. It is recommended that the sole focus on clinical competency of existing medical education and training should be expanded to include the development of the concepts of 'professionalism' and 'patient-centred care' amongst future medical practitioners.

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Footnote

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Conflicts of Interest: Both authors have completed the ICMJE uniform disclosure form (available at <https://jhmhp.amegroups.com/article/view/10.21037/jhmhp-23-98/coif>). The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study received ethics approval from La Trobe University (HEC19251, 30 March 2019) and the approval from the Research Committees of Qian FoShan Hospital and LaiWu Hospital for conducting the study with their patients as described in the methods section. Information on informed consent was included at the beginning of the paper-based questionnaire. All participants were reminded that implied consent to the study was provided by completing and returning the questionnaires. The anonymous nature of the survey was verbally explained to each of the participants by the project staff and relevant information also included in the Participant Information Sheet. The survey did not collect identifying information to protect participants' anonymity.

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