

# Perceptions of professional attributes in medicine: a qualitative study in Hong Kong

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**Objective** Medical professionalism has been widely discussed in western scholarly literature. However, since Hong Kong has a mixed Chinese-western culture, it remains uncertain whether Hong Kong health care professionals, medical students, and patients see medical professionalism in exactly the same way as westerners. The objective of the present study was to explore perceptions of medical professionalism in Hong Kong.

**Design** Individual semi-structured interviews.

**Setting** Medical faculty preceptors, residents, interns, nurses, and students from the Li Ka Shing Faculty of Medicine of the University of Hong Kong. Subjects were recruited at an out-patient clinic of Queen Mary Hospital.

**Participants** We interviewed 39 subjects, including six medical faculty preceptors, six hospital residents, four medical interns, eight nurses, eight out-patients, and seven medical students. The interviews were transcribed and coded. Grounded theory was employed for framing and analysing the interviews.

**Results** A total of 30 primary themes were identified and grouped under three secondary themes, ie 'Expectations of a professional doctor', 'Work values', and 'Patient care'. In general, the primary themes were consistent with recognised professional attributes in western bioethics, such as knowledge and skills, holistic care, and communication skills. A closer analysis suggested that traditional Chinese thought also played an important role in shaping the medical professionalism of Hong Kong. Challenges to be faced by Hong Kong doctors due to recent social changes were also identified.

**Conclusions** Medical professionalism in Hong Kong is shaped by both western medical ethics and traditional Chinese thought. The values treasured by Hong Kong health care professionals as well as technological advance, and the city's proximity to Mainland China makes Hong Kong health care unique. It is important to maintain the present work attitudes and at the same time adapt to new social changes.

**Key words**  
Clinical competence; Delivery of health care; Physician-patient relations; Professional practice

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## New knowledge added by this study

- Perceptions, with explanations, of professional attributes in medicine provided by Hong Kong people.

## Implications for clinical practice or policy

- Provision of a reference for developing and maintaining a professional attitude in clinical practice.

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## Introduction

Medical education is not only a matter of passing on medical knowledge. 'How to be a good and moral doctor' is also the cornerstone of medical education and practice. In recent years, there has been an emphasis on defining, teaching, and assessing medical professionalism. This has resulted in an accumulation of literature on this subject.<sup>1-3</sup> Such material has culminated in the evolution of *The physicians' charter on medical professionalism, learning objectives for medical school education (report one)* and the Accreditation Council for Graduate Medical Education's *General competencies*, both of which consolidate the

role of medical professionalism in practice and in education.<sup>4-6</sup>

Within this discourse, cultural competence has been identified as an important component of quality health care.<sup>7,8</sup> In particular, the unique implications of Chinese culture on clinical care are recognised and discussed.<sup>9,10</sup> Recently, Hong Kong has become one of the most popular destinations for Mainland Chinese medical tourists, which is mainly because Hong Kong health care can provide quality services.<sup>11</sup> Whereas technological advance is an important component of Hong Kong medicine, the work attitude of Hong Kong health care professionals and the values they uphold also count. The present study is a pioneering attempt to explore the perceptions of medical professionalism in the Hong Kong Chinese cultural context. Its results may help explain its success and the challenges still to be faced by Hong Kong health care.

## Methods

We conducted individual semi-structured interviews with six faculty preceptors, each belonging to a different department; six residents from six different departments; four interns from different departments; eight nurses from three different ranks (managerial, advanced practice, frontline); four patients aged 35 years or below, and four who were older than 35 years. All of these subjects were recruited at Queen Mary Hospital (QMH), a tertiary medical centre in Hong Kong Island. We also interviewed four pre-clinical (first- to third-year) students and three clinical clerks (forth- to fifth-year students) of the Faculty of Medicine. The doctors and nurses were recruited through referrals from hospital senior, and the students through referrals from peers. The patients were recruited at an out-patient clinic of the QMH. By recruiting subjects from different areas, ranks and ages, we attempted to maximise objectivity in data collection. However, since there were practical difficulties in carrying out random sampling, we finally recruited most of the subjects by means of referrals and this could be a source of bias.

Each interview lasted 1 hour and consisted of two parts. In part I, the subject was invited to propose attributes that he/she considered a professional doctor should possess. The interviewer then asked the subject to explain the attributes. In part II, the subject was asked to give free comments on some vignettes (nine in all as shown in the Appendix). Most of them were newspaper excerpts and were chosen with reference to David T Stern's framework of medical professionalism.<sup>12</sup> They were aimed at stimulating comments concerning professional attributes not yet discussed by the subject in part 1. For each category of subjects, the interview was

## 對香港醫學專業精神之領會：一項定性研究

- 目的** 西方學術文獻對醫學專業精神已作廣泛的討論。但是，香港作為一個中西文化交融的地方，醫護人員、醫科學生及病人對醫學專業精神的看法會否與西方完全一致仍是未知之數。本研究旨在探討以上人士對香港醫學專業精神的看法。
- 設計** 個別半結構性訪問。
- 安排** 訪問香港大學李嘉誠醫學院的導師、駐院醫生、實習生、護士和學生、以及瑪麗醫院門診部病人。
- 參與者** 共有39名受訪者，包括6名醫科導師、6名駐院醫生、4名實習生、8名護士、8名門診病人及7名醫科學生。訪問後，研究員將錄音筆錄並加以編碼，再用紮根理論分析訪問內容及將要點分類。
- 結果** 共找到30項主題，並把它們編入以下三個次主題：對「專業醫生的期望」、「工作價值觀」，以及「病人護理」。總的來說，我們歸納出的主題，例如「知識與技術」、「整體護理」及「溝通技巧」，與西方生物倫理學中被廣泛認同的專業精神要素是一致的。我們仔細的分析顯示，中國傳統思想對香港醫學專業精神之形成其實也發揮重要作用。此外，我們也找出一些因近年社會變化而為香港醫生帶來的新挑戰。
- 結論** 香港醫學專業精神同時受西方醫學倫理及中國傳統思想所影響。香港醫護人員持守的價值觀、香港的先進技術及其鄰近中國內地的優勢，造就了香港醫護系統獨有的角色。香港醫護人員能保持現有的工作態度以及同時適應社會上的變化相當重要。

continued until 'saturation' was reached (ie no more new points being raised). The initial subject size in each category was set to be seven or eight because according to our experience, saturation was likely to be achieved at that size. At the same time, we were aware that the size could vary depending on actual needs.

All interviews were conducted in Cantonese, recorded on audiotapes with consent, and then transcribed verbatim by two researchers who had received training in qualitative research. The transcripts were analysed independently by each researcher using grounded theory developed by Barney G Glaser and Anselm L Strauss.<sup>13</sup> During the coding process, keywords or phrases were highlighted line-by-line. Segments of transcripts were extracted and grouped under a primary theme with a theme code. The coded transcripts then underwent vigorous comparisons until the two researchers reached 100% agreement. The researchers also reviewed the coded transcripts regularly to determine whether common main themes (secondary themes) emerged. After the coding was completed, the transcripts were translated into English and the themes reorganised in tabular form for presentation. All the data collected

were treated confidential and anonymous. The study was approved by the Institutional Review Board of the University of Hong Kong/Hospital Authority (Hong Kong West Cluster).

## Results

A total of 30 primary themes were raised, and grouped under three secondary themes as discussed below:

### Secondary theme A: expectations of a professional doctor

As shown in the Table, six primary themes raised by the participants were classified under this secondary theme. There was wide agreement that a professional doctor should be accountable to the public, regulated

by a council, have sufficient medical knowledge and good clinical skills, strive for excellence, and enjoy a privileged status in society. In particular, most claimed that medical knowledge and skills were the most important in medical professionalism, as the aim of the profession was to treat disease.

Apart from professional qualifications, being able to make accurate diagnoses, provide explanations to patients and conduct appropriate examinations and treatments were also indicators of erudition. Some patient subjects remarked that a knowledgeable doctor should be able to minimise pain:

“For instance, when a doctor examines me, I will be concerned about whether he is knowledgeable—whether he would make me

TABLE. Primary themes grouped under (a) ‘Expectations of a professional doctor’, (b) ‘Work values’ and (c) ‘Patient care’

Secondary theme	Primary theme
Expectations of a professional doctor	(1) Accountability (frequently appear, mostly stimulated by the vignettes)
	(2) Excellence (frequently appear, mostly raised by subjects without stimulation)
	(3) Medical knowledge and clinical skills (frequently appear, mostly raised by subjects without stimulation)
	(4) Good conduct (raised by a few subjects without stimulation)
	(5) Personal appearance (raised by a few subjects, mostly nurses, without stimulation)
	(6) Being respected (frequently appear, mostly stimulated by the vignettes)
Work values	(1) Altruism (frequently appear, mostly stimulated by the vignettes)
	(2) Acting for patients’ best interest (frequently appear, mostly raised by subjects without stimulation)
	(3) Doing no harm to patients (raised by a few subjects without stimulation)
	(4) Integrity (frequently appear, half stimulated by the vignettes, half without stimulation)
	(5) Being a responsible person (moderately frequent, raised by subjects without stimulation)
	(6) Being ethical in research (raised by a few subjects without stimulation)
	(7) Treating patients without discrimination (raised by a few subjects without stimulation)
	(8) Being objective (raised by a few subjects without stimulation)
	(9) Self-confidence (raised by a few subjects without stimulation)
	(10) Emotion management and empathy (moderately frequent, raised by subjects without stimulation)
	(11) Being enthusiastic at work (moderately frequent, raised by subjects without stimulation)
	(12) Good communication with colleagues (moderately frequent, raised by subjects without stimulation)
	(13) Knowing self-limitations (raised by a few subjects without stimulation)
	(14) Perseverance (raised by a few subjects without stimulation)
	(15) Respecting the profession (raised by a few subjects without stimulation)
	(16) Having a strong sense of mission (raised by a few subjects without stimulation)
	(17) Team spirit (frequently appear, mostly stimulated by the vignettes)
	(18) Willingness of accepting others’ opinions (raised by a few subjects without stimulation)
	(19) Working seriously (raised by a few subjects without stimulation)
Patient care	(1) Communication with patients and patient family members (frequently appear, mostly raised by subjects without stimulation)
	(2) Taking care of patients’ psycho-social well-beings (frequently appear, mostly raised by subjects without stimulation)
	(3) Respecting patients (frequently appear, mostly raised by subjects without stimulation)
	(4) Having patience (raised by a few subjects without stimulation)
	(5) Having a loving heart (moderately frequent, raised by subjects without stimulation)

feel comfortable and avoid causing pain. [If he/she is knowledgeable,] I can perceive that he/she has a method, and can minimise pain."

Striving for excellence was also important, as medical theories, medical technology and drugs were ever advancing. "There is a Chinese saying 'The sea of knowledge has no boundary.' This is to tell us that we should keep advancing our knowledge without rest," said a nurse subject. Apart from knowledge and clinical skills, attributes like interpersonal relationship, understanding and the handling of patients' emotions were also areas for continued enhancement.

Most of the participants agreed that being a doctor was more respected than other occupations in Hong Kong:

"...in Chinese culture, people [particularly elders] would regard a doctor as someone with a high social status, perhaps due to the [Chinese] notion that 'doctors have parents' hearts' or similar views. So, patients see doctors as authoritative figures."

Notably, it was remarked that "the trend is that doctors' social status is not going to be as high as before. The 'distance' between doctors and patients is now getting closer and closer". This was because today's patients know more about disease and are less submissive.

Good conduct is required, both in the workplace and in personal life: "In Chinese culture, a professional doctor is expected to have a high standard of conduct both inside and outside the hospital". He/she should avoid "embezzling public funds, committing drug abuse, or going to a brothel". Some of the nurse subjects added the clothes doctors wear, such as the shirts and pants, were also important.

## Secondary theme B: work values

Nineteen primary themes were categorised under 'Work values', as summarised in the Table. This secondary theme is the largest one and some of its components are noteworthy. For instance, "acting for patients' best interest" was commonly considered as important. In this regard, "a doctor should take the patient's concerns into consideration" but "should not simply follow the patient's requests and lose his/her professional judgement". Moreover, "[a professional] doctor should proactively explain surgical treatment plans to his/her patient...[so that] the patient can understand what to choose as is his/her right. When treating the terminally ill, the doctor should seek ways to make the patients feel most comfortable."

In addition, doctors with this attribute should refuse to benefit themselves at the expense of

patients' interests. For instance, they should not prescribe unnecessarily expensive drugs or "because of face or monetary reasons, hold on to patients by postponing necessary referrals to specialists".

Integrity was also frequently mentioned. Doctors should not, for instance, tell lies to patients or issue unjustified sick leave, because such behaviour erodes public trust about the profession. When participants were asked to discuss whether a doctor can have intimate relationship with a patient, the majority disapproved, mainly because it might tempt the doctor to abuse his/her power: "Since a patient who becomes the doctor's lover might receive better service than others. For instance, he/she might be put at the front of the queue", said a nurse subject.

Patient subjects, however, tended to be lenient about the relationship. Half of them approved: "They [doctors] are also humans". This was acceptable, as long as they [doctors and patients] did not have their "sweet moments during a consultation"; "their dates had to be after work, that's ok".

A majority of the participants held that team spirit was an important element of professionalism, particularly in a hospital setting. A doctor with team spirit would be willing to seek help from, and explain and discuss patients' progress with, colleagues. Hence, good communication with colleagues was also emphasised. Interestingly, in the interviews, nurse subjects were particularly critical about the communication skills of younger doctors. "Sometimes their [younger doctors'] expressions are a bit strong". Furthermore, "even their handwriting... It's hard to read...it's too rough. I can't understand". To comment on the friction between doctors and nurses, one of the participants said, "In recent years, nursing education had advanced quickly. The curriculum is expanding... Therefore, doctors should accept that their 'distance' from nurses is getting less".

Emotion management, ie doctors having good emotional control when facing patients, was also seen as essential, because today's patients were smarter and less submissive. Some of them might be well prepared for their visits (finding information about their diseases on the internet), which could annoy doctors. It was remarked that since such patient behaviour would become a norm, doctors should be emotionally prepared to accept it.

Altruism was discussed, firstly, with reference to the relation between working over-time and professionalism. Some agreed that working over-time was necessary for a doctor to be professional, because it was a doctor's mission to give patients the best possible care. However, some held that it was unhealthy and only "indicates that there is something wrong with the system".

Secondly, participants were invited to comment on doctors who resigned during the severe acute

respiratory syndrome (SARS) epidemic in Taiwan. Many held that under such circumstances doctors should not resign: "This is because doctors have a mission to treat patients. It was unacceptable that they quit due to the perceived life-risk". Moreover, "a person becoming a doctor should expect to bear life-risk. It's just like a fireman". Nevertheless, some participants said that resignations were understandable because "some of them [the doctors] had to consider their own families, wives and children; and having reviewed the issues suitably, I think this course of action is acceptable".

### Secondary theme C: patient care

Five of the primary themes were classified under 'Patient care', as shown in the Table. "Respecting patients" was frequently mentioned. It manifested in several ways. First, "the doctor should respect the patient's beliefs or viewpoints". Second, "The doctor's attitude to patients should be the same, regardless of the disease in question, no matter whether it is sexually transmitted or a mental disorder. All patients must be treated equally". Third, a doctor should be willing to listen to the patient's complaint: "If you let your patients feel that you are listening to them, they will be delighted. This might not help to cure the disease, but is a kind of respect". Fourth, a doctor should respect a patient's decision on the treatment plan even if the patient's views does not coincide with the doctor's. Fifth, treatment should be directed to patients rather than diseases, as nowadays the explosion of medical technology might make doctors forget the importance of face-to-face interactions. Sixth, patient confidentiality should be well protected:

AIDS is an example. "Some patients request the diagnosis not to be disclosed to their families. Patients with terminal cancer might make the same request... such information should only be disclosed with the patient's consent; and then only to first-degree relatives."

This did not mean that doctors should be indifferent to the patient's families. Rather, good communication with patient families was important, particularly for patients with chronic or serious diseases: "The role of patient family members is to look after the patient; and such relatives might have their own financial and psychological pressures. So, they too need our concern". However, regarding the breaking of bad news, our subjects did not condone deceiving a patient about the prognosis if requested by the family:

"Sometimes when there is poor prognosis, the sons and daughters of a patient ask [the doctors] not to tell the patient. In that case, we will explain that the patient has the right to know...My experience is that if you break

bad news to a patient appropriately, the patient will receive it without much trouble. If your communication skill is good, the patient will accept it."

Good communication with patients also included efforts to explain the side-effects of drugs; not to interrupt patient narratives and not to make a patient feel that he/she was in an inferior position. Successful communication could facilitate patient compliance and help maintain a harmonious doctor-patient relationship.

It was widely agreed that a professional doctor should deliver holistic care, ie in addition to physical health, also look after a patient's psycho-social aspects: "Apart from treating disease, perhaps the disease is related to certain social-familial problems. If time allows, a doctor should seek to understand those things". Moreover, he/she should "see whether the patient is disposed to depression, or is already displaying depressive emotions"; those with chronic diseases might have been enduring frustration for a long time.

## Discussion

The professional attributes revealed in this study were highly consistent with those in recognised frameworks and discussions. For instance, 'Acting for patient's best interest' and 'Altruism' fit into the principle of primacy of patient welfare in *The Physicians' Charter*. 'Medical knowledge and clinical skills' and 'Excellence' fit into the framework developed by David T Stern and Herbert M Swick.<sup>1</sup> Virtues such as 'Good conduct', 'Being a responsible person' and 'Perseverance' echoed the advocacy of a virtue-based ethic by Swick et al.<sup>14</sup>

Our interviews also reveal the cultural character of medical professionalism in Hong Kong. For instance, the secondary theme A 'Expectations of a professional doctor' suggests that the image of a professional doctor is similar to that of a *chun-tzu* (the morally ideal person in Confucianism) who, it has been argued, is the model for traditional Chinese physicians.<sup>15</sup> Reference to Chinese culture and Chinese sayings often appear in the subjects' testimonies. This indicates that traditional Chinese thought is embedded, to a significant extent, in our subjects' views of medical professionalism.

Despite this, we found that some traditional Chinese values were being challenged by western social currents. Younger patients, in receipt of western education systems who are frequent internet users, see themselves as more than equal to their doctors, who are traditionally supposed to be a fatherly and authoritative figures under the Confucian hierarchical social structure.<sup>16</sup> Such patients may ask challenging questions and demand

more involvement in medical decision-making. This finding echoes with Kumana and Kay's discussion of the changes of medical professionalism in Hong Kong<sup>17</sup>, and is consistent with the results in studies concerning the relation between patients' education levels, patient trust and patients' desires for power sharing.<sup>18,19</sup>

Challenges also come from nurses. In the present study, we observed friction between nurses and doctors (particularly younger doctors). This can be explained by the rapid development of nursing degree and master programmes in Hong Kong. University education cultivates nursing students to see themselves as professionals with autonomy and critical thinking. Such enhanced self-esteem might explain why nurses are particularly critical of younger doctors. In fact, in Yung's 1996 study<sup>20</sup> of role conception and role discrepancy of Hong Kong nursing students, it was found that nursing degree students "had a significantly higher ideal but lower actual professional role conception than certificate students". To relieve the friction between nurses and doctors, we suggest that new teaching components for doctors' and nurses' roles need to be coordinated and harmonised, by discussing such issues in the medical and nursing curricula.

Our examination of these issues reveals that often there are competing values in situations requiring altruistic behaviour. Our participants' testimonies indicate that altruistic behaviour in medicine depends on several factors.<sup>21,22</sup> For instance, if doctors have a very strong sense of calling, these could override their reservations at critical moments. Similarly they may have competing demands for a private life, the courage to undertake risky tasks, and the respect they might expect within the health care system and in society. Despite these concerns, we are optimistic about this attribute, in view of the altruistic behaviour of Hong Kong health care professionals during the SARS epidemic in 2003.

Half the patient subjects allow intimate relationship between doctors and patients, whereas subjects of other categories largely disapproved. This indicates that patient subjects are less aware of the possibility of power abuse by a doctor in this relationship, especially due to the inferior position of patients in a fiduciary relationship.<sup>23</sup> We suggest that this kind of issue and issues concerning role conflict should be included in the general education syllabus in school.

In the secondary theme C, we noted a balance between patient autonomy and the concept of family. On the one hand, communication with and respect for patient's family were encouraged. Many of our subjects saw patient family members as co-sufferers in need of support, and believed that the family support would eventually benefit the patients.

On the other hand, our participants were not completely submissive to family autonomy, which is a recognised component in Chinese bioethics.<sup>24-26</sup> They rejected unreasonable family requests, such as deceiving a terminal patient about the diagnosis and prognosis.

One limitation of this study was that it was conducted in a single hospital and private general practitioners were not included. Moreover, within the hospital we were not able to cover all departments and did not include in-patients as subjects. This was likely to produce selection bias to some degree. Secondly, since recruitment was mainly by referral rather than random sampling, self-selection bias and non-response bias may have occurred. Reporting (information) bias is also possible as, for instance, some of the subjects might have felt uncomfortable to criticise their seniors or themselves. Despite this, we attempted to collect the widest range of views, and eventually obtained a variety of in-depth comments which granted the study considerable information and validity. We suggest that a follow-up study involving private general practitioners, private specialists, as well as their nurses and patients could also be valuable.

## Conclusions

In the present study, we organised professional attributes in medicine into three main categories: (1) expectation of a professional doctor, (2) work values, and (3) patient care. In particular, the image of a professional doctor as a *chun-tzu*, with virtue ethics, communication skills, attitudes encompassing holistic care, and a balance between patient and family autonomy appeared to be pronounced. In summary, our subjects' perceptions of medical professionalism are constituted by western bioethics and traditional Chinese thought. This professionalism, together with our use of the Chinese language and our proximity to Mainland China, makes Hong Kong health care unique and exemplary for other cities in the Mainland. As Professor Chen Zhu, Minister of Health, said in his keynote address for the Hong Kong Hospital Authority Convention 2011, China needs to draw on the successful experience of Hong Kong for its health care system reform.<sup>27</sup> Therefore, it is important for Hong Kong health care professionals to maintain their quality work and face upcoming challenges. The implications of this could be wide and profound.

## Appendix

Additional material related to this article can be found on the HKMJ website. Please go to <<http://www.hkmj.org>>, search for the appropriate article, and click on **Full Article in PDF** following the title.

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Appendix. Vignettes used in part II of the interviews

**The vignette to stimulate comments concerning knowledge and skills**

一個姓X的中年男性，因為感覺身體不舒服，到某家醫院做身體檢查，CT檢查顯示，他的右下肺有一個包塊，醫生在檢查單上寫下“考慮肺癌不排除”幾個字。然而這幾個字卻嚇壞了患者，同時嚇壞了他的家人。考慮到病情嚴重，他們立即轉院到Y醫院，住進呼吸內科，“當時患者的家屬非常傷心。”醫生說。但他經過重新檢查，排除了“肺癌”這個結論，那個小包塊應該是個異物。果然不出所料，醫生採用支氣管鏡，從肺部取出一塊1.2 x 1.2 cm大小的豬排，估計是在吃飯時不小心嗆進去的。在取出異物後的第二天，連續高燒幾天的X先生便退烧了，並很快離開了醫院。

**The vignette to stimulate comments concerning beneficence/humanism**

**仁醫救回心臟病發工人**

一名跟車工人上午送貨時，疑心臟病發昏迷，附近診所醫生趕至急救，並要求救護員幫手，救回男子一命。在上午11時多，57歲跟車工人送奶品到Z商場麵包店時，突然暈倒，麵包師傅立即走到附近西醫求救。該名男醫生立即趕至現場，為工人進行心外壓救援，但發現工人已沒有心跳。醫生突想起，有病人召喚了一輛非緊急救護車到診所，他立即要求救護員帶同手提心臟除顫器趕至，為工人進行電擊急救，終救回工人一命，並送往醫院急救。

**The vignette to stimulate comments concerning altruism**

**衝越醫院封鎖線高喊要回家  
台遭隔離醫護跳窗逃走**

台灣當局前天突然宣布將懷疑集體感染非典型肺炎的X醫院關閉，並隨即把在醫院內的近千多人就地隔離，結果引起混亂。有些不願被強制隔離的醫護人員竟跳窗逃走，還有數十名情緒激動的醫護人員企圖衝開警方的封鎖線。

**The vignette to stimulate comments concerning integrity**

**醫生涉與不同精神科女病人同居跳舞  
否認與病人不恰當接觸指控**

現為私人執業醫生的X，在任職Y醫院及Z精神科診所工作期間，涉嫌犯下多項專業失當行為，更被揭出與病人發生親密關係，曾提供金錢資助及共賦同居。醫務委員會昨日展開聆訊，X只承認8項未經批准擅查電子病歷等指控，7項與病人發生不恰當關係和接觸，以及留有病人標籤和電話號碼的指控則予以否認。

**The vignette to stimulate comments concerning excellence**

**院長帶頭念書進修  
Y醫院10人考上研究所**

活到老學到老，Y醫院鼓勵職員終身學習、充實自己，院長X率先帶頭在職進修，職員相繼跟進，利用閒暇之餘重拾書本，相互督促念書，歷經數月苦讀，竟有10人陸續考上研究所，重新體驗當學生的滋味。

**The vignette to stimulate comments concerning accountability**

**Y院打錯針女醫生  
罰3年無薪加無職升**

Y醫院21歲血癌女病人X，於今年6月15日被腫瘤科女醫生打錯針致死亡，調查報告指屬人為錯誤。醫管局一直沒有公布如何懲處有關的醫護人員，直至傳媒查詢才作回應，指打錯針的醫生由今年11月起被罰3年不可以升職及沒有人工加，女醫生之上司及醫院管理層則不用受懲處。

**The vignette to stimulate comments concerning acting for patient's best interest**

**距急症室百米派3公里外白車  
馳援送院兜大圈心臟病漢失救**

患有心臟病的56歲男子，昨乘貨車至Z道時不適暈倒，同車的兒子着司機駛到Y醫院大門求救。司機在大堂向身穿制服者求助，惟對方聲稱「唔識救」，隨即離去，稍後由途經的醫生報警和協助施救。

現場與急症室僅相距百米，惟消防處接報後，卻指派3公里外的消防局調派救護車出動，途中又遇上塞車，要由另一輛救護車接力趕至，惟事主於24分鐘後始送抵近在咫尺的急症室，終告返魂乏術。醫管局至今凌晨仍未回應。

**The vignette to stimulate comments concerning the social distance between doctors and patients**

**Noble and respectable position**

高高在上，被受敬重

**The vignette to stimulate comments concerning teamwork**

團隊合作

Teamwork