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PERCEPTIONS OF MEDICAL ETHICS AND PROFESSIONALISM AMONG PRACTICING PHYSICIANS OF AZAD JAMMU AND KASHMIR: A MIX-METHOD STUDY OF ETHICAL DILEMMAS

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Abstract

Background: *The evolving nature of clinical practice, patient interactions, and advancements in medical technology may influence how practicing physicians perceive and apply medical ethics and professionalism. Aim: Therefore, this study assessed how factors such as experience, specialization, and frequency of ethical dilemmas and modern challenges shape physicians' views on ethics and professionalism.* ***Methodology:*** *A mix-method survey-based study was conducted among practicing physicians in Azad Jammu and Kashmir using stratified random sampling. Data were collected through self-administered questionnaire assessing perceptions of medical ethics and professionalism.* ***Results:*** *The demographic distribution showed that participants were evenly split between the 31-40 and 41-50 age groups (30% each), with males comprising 50% and females 40% of the sample. Most had 2-5 years (30%) of practice. General practitioners made up 30% while hospitals were the most common workplace (45%). The study found that physicians ranked non-maleficence (mean = 3.25) as the top ethical principle. There were notable links between medical specialty and views on non-maleficence, and between years of practice and both autonomy and non-maleficence. Common ethical dilemmas included patient confidentiality (68.8%) and informed consent (62.5%). Although 75% of physicians received ethics training during medical school, only 43.8% engaged in ongoing ethics-focused professional development. Key challenges included managing conflicts of interest, addressing cultural and religious sensitivities, and handling unethical behavior by colleagues.* ***Conclusion:*** *In conclusion, physicians prioritized non-maleficence, with significant links between years of practice, medical specialty, and ethical views. Future research should explore how targeted ethics training can further enhance ethical decision-making across specialties.*

Keywords: *Business Models, Emerging Markets, Market Research, Local Partnerships, Innovation Strategies, Competitive Edge, Case Studies, Strategic Considerations, Economic Environment, Cultural Adaptation.*

Introduction

Medical ethics and professionalism are fundamental to clinical practice, ensuring healthcare remains both competent and morally grounded. The primary ethical principles—autonomy, beneficence, non-maleficence, and justice—guide physician-patient interactions. Autonomy allows patients to make informed healthcare choices, while beneficence directs physicians to act in the patient's best interest. Non-maleficence requires avoiding unnecessary harm, and justice demands fair allocation of healthcare resources [1]. Professionalism, closely linked to these principles, fosters trust between physicians, patients, and the healthcare system, sustaining the moral foundation of medicine. As new technologies, complex treatments, and rising patient expectations challenge these ethical standards, physicians must balance these interactions with professionalism to ensure patient care remains ethical and clinically sound, despite the rapid evolution of medical practice and societal expectations [2].

Modern healthcare presents numerous ethical challenges that can hinder physicians' ability to consistently uphold medical ethics and professionalism. End-of-life care, for instance, involves complex decisions around withdrawing life-sustaining treatments, requiring a balance between patient autonomy and clinical judgment [3]. The digital age further complicates patient confidentiality, as electronic records and telemedicine increase the risk of data breaches. Informed consent remains challenging, with patients needing to fully grasp the risks and benefits of increasingly complex procedures. Additionally, the allocation of limited resources, like ICU beds or organs, forces physicians into difficult, ethically-charged decisions [4]. High workloads, burnout, and healthcare commercialization can strain doctor-patient relationships, impacting professionalism and ethical decision-making. Financial incentives in healthcare also introduce potential conflicts of interest, possibly compromising patient welfare [5].

Practicing physicians play a crucial role in upholding ethical standards, as their interactions with patients and colleagues directly impact the quality of healthcare. Ethical decision-making is central to clinical practice, influencing patient care management, resolving conflicts, and handling sensitive issues like end-of-life decisions and scarce resource allocation [6]. Physicians' ethical perceptions are essential for maintaining patient trust and satisfaction, as patients rely on their clinicians to act transparently and respect their autonomy. This ethical framework enhances patient care and supports better healthcare outcomes by ensuring decisions are both clinically effective and morally sound. With advancing medical technologies, evolving policies, and shifting social expectations, physicians must engage in continuous professional development to stay aligned with current ethical standards and professional conduct [7]. Frequent ethics education prepares physicians to address new challenges, reinforcing professionalism and supporting a healthcare system founded on clinical excellence and ethical integrity, which bolsters public confidence and promotes patient welfare.

To address the gap in understanding how practicing physicians navigate ethical challenges in complex clinical environments, this study explores the impact of experience, specialization, and the frequency of ethical dilemmas on physicians' perspectives regarding medical ethics and professionalism. Unlike existing research that predominantly focuses on medical students and early-

career physicians, this study emphasizes the evolving ethical views of seasoned practitioners. With years in practice, patient dynamics, and advances in technology potentially shaping ethical perspectives, it is crucial to assess these factors to identify areas where ongoing ethical training and support may enhance healthcare professionals' commitment to high ethical standards. The goal is to emphasize the importance of continuous professional development in upholding medical ethics across all career stages.

Materials and Methods

A mix-method survey was conducted in 2023 at medical institutes in Azad Jammu and Kashmir to evaluate the perceptions of practicing physicians regarding medical ethics and professionalism. The study included physicians from various specialties with a minimum of two years of experience, excluding medical students, residents, and those with less experience. Stratified random sampling ensured diverse representation across specialties and experience levels, with a sample size of 80 determined using the formula, $n = (Z^2 \times p \times (1 - p))/E^2$ where the primary outcome variable was the incidence of ethical decision-making failures among physicians. An estimated proportion of 0.5 and a margin of error of 0.05 were used, with adjustments made for a 20% anticipated non-response rate. A structured, self-administered questionnaire based on literature on medical ethics and professionalism collected demographic data (age, gender, years in practice, specialty, and workplace) and assessed views on ethical principles—autonomy, beneficence, non-maleficence, and justice—as well as professionalism and ethical dilemmas such as informed consent, confidentiality, and resource allocation, using four points Likert-scale questions. Participants also provided information on ethics training during their education and ongoing development, with open-ended questions on specific ethical challenges encountered in practice. The questionnaire's validity and reliability were established through pre-testing with a small physician group to ensure clarity and make necessary content adjustments.

The survey was conducted using online platforms (e.g., Google Forms, Qualtrics) and paper forms in hospitals and clinics. Physicians were recruited through professional networks and medical associations, with informed consent obtained to ensure confidentiality and voluntary participation. Data analysis included descriptive statistics for participant demographics and ethical perceptions, while chi-square tests assessed relationships between categorical variables like specialty, years of experience, and ethical views. Thematic analysis was conducted to identify common ethical challenges faced by practicing physicians. The data analysis was performed using SPSS software.

The study protocol was approved by the institutional review board of District headquarters hospital AJK, Neelum (Ref: 2188). Participant data were anonymized to protect privacy, and participants were informed that their participation was voluntary and that they could withdraw from the study at any time without any consequences.

Results

Demographic distributions of physicians

Table 1 presents the demographic distribution of participants, including age, gender, years of practice, medical specialty, and workplace setting. Participants were primarily in the 31-40 and 41-50 age groups (30.0% each, 24 participants). The 51-60 age group comprised 20.0% (16 participants), while those aged 61 and above accounted for 10.0% (8 participants). Gender distribution was balanced, with males at 50.0% (48 participants) and females at 40.0% (32 participants). In terms of experience, 30.0% (24 participants) had 2-5 years, 25.0% (20 participants) had 6-10 years, 20.0% (16 participants) had 11-15 years, and 25.0% (20 participants) had 16 or more years. Medical specialties included general practitioners (30.0%, 24 participants), internal medicine (25.0%, 20 participants), surgeons (20.0%, 16 participants), pediatricians (15.0%, 12 participants), and psychiatrists (10.0%, 8 participants). Most participants worked in

hospitals (45.0%, 36 participants), followed by clinics (35.0%, 28 participants), private practices (15.0%, 12 participants), and other settings (5.0%, 4 participants).

Table 1Distribution of participants based on Age, Gender, Practice, Spatiality and workplace setting

AGE DISTRIBUTION OF PARTICIPANTS	
AGE RANGE	Count (Percentage)
31-40 YEARS	24 (30.0%)
41-50 YEARS	24 (30.0%)
51-60 YEARS	16 (20.0%)
61 YEARS AND ABOVE	8 (10.0%)
GENDER DISTRIBUTION OF PARTICIPANTS	
GENDER	Count (Percentage)
MALE	48 (50.0%)
FEMALE	32(40.0%)
YEARS OF PRACTICE DISTRIBUTION	
YEARS OF PRACTICE	Count (Percentage
2-5 YEARS	24 (30.0%)
6-10 YEARS	20 (25.0%)
11-15 YEARS	16 (20.0%)
16 YEARS AND ABOVE	20 (25.0%)
MEDICAL SPECIALTY DISTRIBUTION	
MEDICAL SPECIALTY	Count (Percentage)
GENERAL PRACTICE	24 (30.0%)
INTERNAL MEDICINE	20 (25.0%)
SURGERY	16 (20.0%)
PEDIATRICS	12 (15.0%)
PSYCHIATRY	8 (10.0%)
WORKPLACE SETTING DISTRIBUTION	
WORKPLACE SETTING	Count (Percentage)
HOSPITAL	36 (45.0%)
CLINIC	28 (35.0%)
PRIVATE PRACTICE	12 (15.0%)
OTHER	4 (5.0%)

Perception of physician regarding Ethical principals

The survey results on physicians' perceptions of key ethical principles, measured using a Four point Likert scale, reveal the relative importance they assign to each principle in their practice (Table 2). The principle of non-maleficence, or "non-maleficence," received the highest priority, with a mean score of 3.25 (SD = 0.73), ranking first among the four principles. Justice, which emphasizes fairness in medical treatment and the equitable allocation of healthcare resources, was ranked second with a mean score

of 3.20 (SD = 0.91). Autonomy, reflecting respect for patients' rights to make their own decisions, ranked third with a mean score of 3.19 (SD = 0.88). Beneficence, the principle of acting in the best interest of the patient, ranked fourth with a mean score of 3.09 (SD = 0.78). Despite being ranked last, this principle still received relatively high importance, indicating that it remains a key consideration in clinical decision-making. The total distribution of responses showed that 82.8% of the ratings fell in the higher end of the scale (3 or 4).

Table 2Perceptions of key ethical principles among physicians based on four points likert-scale responses

Statement	*1*	*2*	*3*	*4*	*Mean±SD*	*Rank*
I believe that the principle of autonomy (respecting patients' rights to make their own decisions) is fundamental in my practice.	5 (6.2%)	10 (12.5%)	30 (37.5%)	35 (43.8%)	3.19±0.88	III
I believe that beneficence (acting in the best interest of the patient) guides my clinical decisions.	3 (3.7%)	12 (15.0%)	40 (50.0%)	25 (31.3%)	3.09±0.78	IV
I prioritize non-maleficence (do no harm) in my medical practice.	2 (2.5%)	8 (10.0%)	38 (47.5%)	32 (40.0%)	3.25±0.73	I
I believe that justice (fairness in medical treatment and resource allocation) is essential in healthcare.	6 (7.5%)	9 (11.2%)	28 (35.0%)	37 (46.3%)	3.20±0.91	II
Total	16 (5%)	39 (12.2%)	136 (42.5%)	129 (40.3%)		

On likert scale, 1= Strongly disagree, 2= Disagree, 3= Agree and 4= Strongly agree. SD stands for standard deviation.

Chi square test for relationship of medical specialty and years of practice with ethical perceptions

The results of the chi-square test for the relationship between medical specialty and ethical perceptions are presented in Table 3. The analysis showed that there is no significant relationship between medical specialty and perceptions of **autonomy** ($\chi^2 = 8.15$, $p = 0.086$), **beneficence** ($\chi^2 = 6.02$, $p = 0.198$), or **justice** ($\chi^2 = 9.87$, $p = 0.099$), as their p-values exceed the significance threshold of 0.05. However, a significant relationship was found between medical specialty and perceptions of **non-maleficence** ($\chi^2 = 12.45$, $p = 0.031$). The chi-square test results for the relationship between years of practice and

ethical perceptions are presented in Table 4. The analysis reveals relationships between years of practice and perceptions of both autonomy ($\chi^2 = 10.23$, $p = 0.017$) and non-maleficence ($\chi^2 = 9.88$, $p = 0.022$), indicating that views on respecting patients' autonomy and the importance of "non-maleficence" differ significantly based on the number of years in practice. However, no significant relationships were found for beneficence.

Table 3: Chi-Square test for relationship between medical specialty and ethical perceptions

Ethical Perception	χ^2 Value	Degrees of Freedom	p-value	Significant ($\alpha = 0.05$)
Autonomy	8.15	4	0.086	No
Beneficence	6.02	4	0.198	No
Non-Maleficence	12.45	4	0.031	Yes
Justice	Justice	4	0.099	No

Table 4: Chi-Square test for relationship between medical specialty and ethical perceptions

Ethical Perception	χ^2 Value	Degrees of Freedom	p-value	Significant ($\alpha = 0.05$)
Autonomy	10.23	3	0.017	Yes
Beneficence	5.78	3	0.123	No
Non-Maleficence	9.88	3	0.022	Yes
Justice	6.45	3	0.091	No

Frequency of Ethical Dilemmas Encountered by Physicians

The study explored the frequency of ethical dilemmas encountered by physicians, as shown in Table 5. The most commonly reported ethical dilemma was patient confidentiality, which was encountered by 55 physicians, representing 68.8% of the respondents. The second most frequent issue was informed consent, reported by 50 physicians (62.5%). Ethical dilemmas related to end-of-life care were experienced by 45 physicians (56.3%). Challenges related to resource allocation were cited by 40 physicians, making up 50% of the sample. Lastly, other ethical dilemmas, which did not fit into the predefined categories, were noted by 20 physicians (25%).

Table 5: Frequency of Ethical Dilemmas Encountered by Physicians

Ethical Dilemma	Frequency (Select all that apply)
Informed Consent	50 (62.5%)
Patient Confidentiality	55 (68.8%)
End-of-Life Care	45 (56.3%)
Resource Allocation	40 (50%)

Other	20 (25%)

Participation in medical ethics education

The survey results indicate that the majority of physicians received formal training in medical ethics during their medical education. Out of 80 respondents, 60 physicians (75%) reported having received such training, while 20 physicians (25%) did not (Table 6). However, participation in ongoing professional development programs focused on ethics was less common. Only 35 physicians (43.8%) indicated that they had participated in these programs since becoming practicing physicians, while 45 physicians (56.3%) had not engaged in further ethics-related education.

Table 6: Physicians' Training and Participation in Medical Ethics Education

Questions	Yes	No	Total
Did you receive formal training in medical ethics during your medical education?	60 (75%)	20 (25%)	80 (100%)
Have you participated in any ongoing professional development programs focused on ethics since becoming a practicing physician?	35 (43.8%)	45 (56.3%)	80 (100%)

Top three challenges faced by physicians

Many physicians noted the difficulty of navigating conflicts of interest, such as those arising from relationships with pharmaceutical companies or personal financial incentives. They emphasized the challenge of maintaining patient trust and ensuring that external influences do not affect their clinical decisions or compromise their commitment to impartial, patient-centered care.

Physicians frequently encounter situations where patients' cultural or religious beliefs conflict with standard medical practices. These instances often lead to ethical dilemmas when patients or their families request treatments or refuse interventions based on their beliefs, even when these diverge from the medically recommended course of action. Physicians highlighted the challenge of balancing respect for these beliefs while striving to deliver optimal care.

A number of physicians described the ethical challenge of suspecting unethical behavior by colleagues. These situations, which may include issues related to patient care, documentation, or professional conduct, often create discomfort. Physicians articulated apprehensions regarding the potential impact on professional relations, and patient safety and workplace dynamics, making it hard to report such behavior through direct confrontation.

Discussion

The demographic attributes of the research contributors reflect current trends in the medical profession, consistent with recent literature. The balance between mid-career and experienced physicians highlights a workforce that blends expertise with adaptability, essential in a rapidly evolving medical landscape. Faerber et al. [8] note that mid-career

physicians excel at integrating innovations while leveraging substantial clinical experience. Gender representation is more equitable, aligning with global trends of increased female participation in medicine, though leadership disparities remain [9]. Despite rising numbers of women in the field, inequalities in leadership and pay persist [10]. The distribution of years of experience suggests that clinical decision-making matures over time; early-career graduates often struggle with confidence, while senior physicians face challenges related to changing standards, as indicated by Sox et al. [11]. The variety of medical specialties, particularly the prevalence of general practitioners and internal medicine specialists, underscores the critical role of primary care in early disease detection and management [12].

The survey results revealed that non-maleficence ranked highest among physicians, consistent with literature highlighting its foundational role in medical ethics and patient safety [13]. The emphasis on justice reflects increasing awareness of healthcare inequities, particularly during global health crises like the COVID-19 pandemic, where resource allocation became critical [14]. Although autonomy was ranked third, it underscores the importance of patient-centered care and informed decision-making, emphasizing the need for a balance between patient autonomy and physician guidance [15]. While beneficence received the lowest ranking, its significant score indicates that acting in patients' best interests remains vital. Conflicts can arise between beneficence and autonomy when patient wishes diverge from what physicians consider beneficial [16]. The overall strong commitment to ethical principles, as shown by high Likert scale responses, reinforces that physicians integrate these principles into practice, essential for maintaining trust and ensuring morally sound care [17].

The results of the chi-square analysis provide variability in how ethical perceptions vary across medical areas and experience of practice. The association between medical specialty and perceptions of non-maleficence recommends that various specialties may prioritize the principle of "non-maleficence" more strongly, likely due to the nature of the risks inherent in their practice. For instance, specialties such as surgery, where the risk for harm is higher due to invasive measures, may emphasize non-maleficence more than others. This supports with results in recent literature indicating that specialties with higher procedural risks tend to focus more on minimizing harm [18, 19]

On the contrary, the significant association between years of practice and perceptions of autonomy and non-maleficence advise that experience impact how physicians arrange these principles. More knowledgeable physicians might place greater importance on respecting patient autonomy, likely due to increased exposure to complex ethical situations where patient choice and informed consent are important [20]. The importance of non-maleficence might grow with experience as physicians become more sensitive to the possible harms that could arise from mediations [21]. The lack of a relationship between years of practice and the principles of beneficence or justice may suggest that these values are important at all stages of a physician's career, showing their central role in ethical medical practice. These findings underscore the nuanced ways in which both specialty and experience shape ethical perceptions, offering important implications for ethics training and continuing education in the medical field.

The survey highlighted significant ethical issues in medicine, with patient confidentiality emerging as the greatest challenge. This reflects recent trends concerning data privacy and sensitive information, particularly in the era of digitalization and electronic medical records [22]. The frequent dilemmas surrounding informed consent align with literature emphasizing the complexities of ensuring patients fully comprehend the risks and benefits of medical interventions. Ethical end-of-life care also remains a critical focus, intertwining discussions on patient autonomy, palliative care, and life-sustaining treatment decisions [23]. Resource allocation issues underscore the ongoing challenge of balancing limited healthcare

resources with individual patient needs, a concern intensified by recent global health crises [24]. Moreover, ethical dilemmas extend beyond predefined categories, illustrating that medical practice is context-dependent and necessitates adaptable, holistic approaches for effective ethical decision-making.

The survey results reveal a strong foundation of formal ethics education among physicians, with 75% of respondents reporting ethics training during their medical courses. This aligns with current medical school curricula that incorporate ethics into both theoretical and practical training to prepare future physicians for the complexities of clinical practice [25]. However, the relatively low participation in continuous professional development programs on ethics—only 43.8% of doctors reported engagement—highlights a gap in ongoing ethics education. This is concerning given the evolving nature of medicine, where new ethical challenges arise alongside technological advancements and resource constraints [26]. To address this, it is recommended that continuing ethics education be leveraged as a tool for maintaining ethical competence throughout physicians' careers [27].

Physicians highlighted several key ethical issues, with conflicts of interest—particularly involving the pharmaceutical industry and personal finances—being the most significant. These conflicts undermine patient trust and decision-making integrity, emphasizing the need for transparency and institutional policies against undue influence [28]. Cultural and religious sensitivities also pose ethical challenges, requiring physicians to balance respect for patient beliefs with optimal care through effective communication and empathy [29]. Additionally, discomfort in reporting colleagues' unethical behavior complicates the moral imperative to uphold standards, underscoring the importance of fostering accountability and open communication in healthcare teams to promote ethical practice and safety [30]. Future research should explore the impact of ongoing medical ethics education on decision-making across specialties and experience levels, with longitudinal studies examining how evolving healthcare challenges shape ethical perspectives. Integrating ethics training into continuing professional development could further equip physicians to handle complex ethical dilemmas in practice.

Conclusion

Our study provides a comprehensive assessment of the demographic characteristics, professional backgrounds, and workplace settings of physicians, along with their perceptions of ethical principles. The results indicate a relatively balanced distribution of gender and professional experience among the participants, with a pronounced emphasis on the principle of non-maleficence. Significant associations were found between medical specialty and non-maleficence, as well as between years of practice and autonomy. These findings suggest that both a physician's experience and specialization significantly influence their ethical perceptions.

Conflict of interests

All the authors stated that they do not have any conflict of interest

Authors' contributions

All the authors have equally participated in this work.

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