# CLASSROOM DEBATE: "ALL MEDICAL STUDENTS SHOULD BE ABLE TO DEMONSTRATE COMPETENCY IN AUTONOMY, LEADERSHIP AND PROFESSIONALISM IN MANAGING RESPONSIBILITIES "AT THE END OF THEIR MBBS PROGRAMME

***Soe-Soe-Aye; Deeben C; Prem Kumar A; Arivalagan P; Sathiajothi S; Heiilajaa R; Logithasan M; Insyirah ZA; Manesha G; Kierthana SR; Kunasanggari C; Keiswini L; Metahra S; NayLinn; Puteri M.**

*Professor, Head of Paediatrics, Faculty of Medicine, Asia Metropolitan University, Johor, **MALAYSIA**
profsoe14@gmail.com

## ABSTRACT

A classroom Debate on "All medical students should be able to demonstrate competency in autonomy, leadership and professionalism in managing responsibilities at the end of their MBBS programme" had been conducted as an online Teaching learning activity during the MCO 3.0 in Malaysia. The activity had been organized by the 12 students of the rotation 5, Year 3 students (09/ 2018), during the Paediatrics posting of 8 weeks' duration in addition to other teaching learning activities. The aim of this activity is to foster learning with a unique learning strategy; to enable students to develop constructive arguments to support opposing views of the given topic. The students had been briefed on day 1 of the posting and the topic given by the Course Coordinator. The rules and regulations had been presented at start of the Debate session held in 4$^{th}$ week of posting, by the Chairperson. The speakers were allocated a total of 35 minutes per group strictly managed by the two timers. The 3 speakers each from the proposition and the opposition groups spoke, in alternate turns, to put across the message for or against the motion. A panel of 4 adjudicators scored the performances according to marking scheme template. The other students did the photography and video documentation. The Best speaker and the Best group were awarded prizes. all prizes being sponsored by principal author. Conclusion is according to the winning team message that all medical students should be able to demonstrate competency in autonomy, leadership and professionalism in managing responsibilities at the end of their MBBS programme.

**Keywords:** Classroom debate; autonomy; leadership; professionalism; MBBS programme.

## INTRODUCTION

Medical students are future medical doctors, and very soon they are going to "the final frontier" to be exposed to a situation where patient care is influenced by different health related profit-making corporate groups. Therefore, internationally medical schools are giving much quality time and effort regarding teaching and curriculum design, in order to generate educational atmospheres, that will ensure professionalism. Medical professionalism promotes the ethical and moral duties and responsibilities of a doctor to his/her patients. The tenets of professionalism and ethics in Medicine are based on the principles of beneficence, non-maleficence, respect for autonomy of the patient and justice in health care. The teaching of medical ethics will have to be explicitly enshrined in the medical curriculum as they are relevant to the practice of modern medicine. The role of the teacher - mentor is now a reality in identifying the gaps that exist in the medical curriculum with regards to ethics so as to rectify deficiencies in the education process. The principal author as the Professor/Head of Paediatrics felt that the topic for this DEBATE session is most opportune and relevant in order to highlight

the importance of Autonomy, Leadership, & Professionalism in managing responsibilities by the medical students at the time of graduation in the MBBS program It also exemplify as one of the 11 Program Learning Outcomes.

## LITERATURE REVIEW

All the students and the faculty did the literature review relating to topic. Please refer to the List of the References

## OBJECTIVE

The objective of this paper is to showcase the presentations made on the Debate topic by the 3 speakers each for Proposition and Opposition group and highlight the Introduction, Remarks and Conclusions made upon the Debate session by the faculty.

## METHODOLOGY

All the 12 students (09/2018) posted to the Paediatrics posting in rotation 5 for 8 weeks, participated in the conduct of the online classroom Debate session introduced as one of the Teaching Learning activities during the MCO.3.0 in Malaysia. The aim of this activity is to foster learning with a unique learning strategy; to enable students to develop constructive arguments to support opposing views of the given topic; to encourage critical thinking; to raise students' awareness that most issues are not straightforward and that students should learn to form opinions about their position that they can explain or defend with factual evidence. The students elected their own Chairperson and Timer for the session and 3 speakers each for PROPOSITION and OPPOSITION Team of the topic given by Course coordinator on day 1 of the posting. Each one of them did a Literature review as evidenced by the list of References given. The rules and regulations for conduct of the Debate session and the marking scheme for grading of their performances are given in the students' guidebook.

## FINDINGS (PRESENTATIONS)

The speakers spoke in turns, one from each group alternating with speaker from other group. However, the 3 presentations from each group are collated and given as below.

## A. PROPOSITION TEAM

### 1ST SPEAKER: MS METAHRA SRITHAR

The motion for today's debate is "All medical students should be able to demonstrate competency in autonomy, leadership and professionalism in managing responsibilities at the end of the MBBS programme". We strongly believe that is the indisputable truth.

According to the Oxford learner's dictionary, competency is the ability of an individual to do something well. Autonomy is expressed as an ability of physicians to make rational and uninfluenced decisions. The New Oxford Dictionary of English defines leadership as 'the action of leading a group of people or an organization'. Subsequently, Professionalism is the combination of qualities such as accountability, excellence, duty, honour, integrity and respect for others connected with trained and skilled individuals.

Professionalism in medicine requires the doctor to serve the interest of the patient and community above his/herself interest.

We, as today's proposition team have structured our case as follows, I, as the first speaker from the proposition side will be talking on competency of autonomy, whereas, our second speaker,

Kierthana Shri will be talking about leadership in managing responsibility, and lastly, our third speaker Prem Kumar, will be talking about professionalism in managing responsibility.

I would like to begin by saying that by demonstrating competency in autonomy, it will ensure doctor's judgement concerning patient's treatment, would be , not disturbed nor not affected by outside, non-medical factors. Clinical work freedom, refers to the ability of a doctor to decide and provide care to a patient without being limited by organizational procedures, financial concerns, performance measurement systems, or any other managerial control. In fact, you can find many examples in real life where doctors are required to solely make decision in any circumstances prioritizing the welfare of their patient and only deciding the best for their patients. For example, a doctor's decision over which tests to order, which drugs to prescribe or which examinations or procedures to perform. This shows that doctors are seen as autonomous professionals using their knowledge and skills in medical science to manage their responsibility to treat the patient. They should not get influenced by any other factor because it could end up in danger and catastrophe for the patient. One day we, students are going to be in a position, where the patient's lives lie in our hands. At the end of this MBBS course we must be able to turn ourselves into an able decision maker. This is very important in order to carry out the responsibilities as a good doctor. Thus, in our medical school we should learn and demonstrate competency of autonomy in order for us to decide on our own. Because a wrong decision can cost the life of the patient and there is nothing more important than a patient's life for a doctor.

My second point would be, decision making is a fundamental principle of professional competency in autonomy. Decision making in medicine is the ability to utilize professional judgment to make clinical decisions that best meet the needs of a patient. Competency in autonomy is very essential in making decisions which are aimed at promoting the patient's well-being. But I am not saying competency in autonomy is absolute freedom, but somewhat, it lies on a continuum and comes with responsibilities. In order to care and treat patients, a doctor requires competency in autonomy to practice their professional judgement to make decisions that best meet the needs of their patients. It is fundamental in the patient-doctor relationship. What I am trying to impart is, an appropriate level of autonomy is essential to foster the therapeutic relationship and promote thoughtful dialogue between patients and doctor. I am not denying the patient's autonomy. Yes, I do acknowledge that patient do have the rights to choose treatment plan which suits them best. But what I am emphasizing is, it is very important to have competent autonomy skills for a doctor especially in a situation where it is an emergency and where a patient is unable to make the call or no next of kin is available to decide on the patient's behalf or a situation where the patient is not in the capacity to provide informed consent. Thus, a doctor should be able to act independently on the patient's behalf in a consistent manner with what any reasonable person in that situation would prefer. In short, a doctor's competency in autonomy skills can provide treatment for the patient without delay and a life can be saved. We as a future doctor whose mission is to serve the public must pause and realize the enormous importance of competency in autonomy.
In conclusion, I am upholding my stand strongly on the debate theme.

**2ND SPEAKER: MS KIERTHANA SHRI**

I, as the second speaker of the proposition team, strongly believe the Debate's motion.
However, first, I would like to address a few things that the first speaker from the opposition had stated . He said that the junior doctors do not have the rights to make decisions and thus do not require the competency in autonomy at the end of the MBBS programme. What I would like to ask is, would not the junior doctors ever become senior doctors; and won't these senior

doctors have to make decisions on their own? So why wait for the last minute to develop these skills? Why shouldn't we start early? Just ponder on that. Secondly, he had stated that patients should be given the rights to make decisions on what type of treatment they want to receive. Well, we here, do not stop the patients, from making decisions, but we, as the more educated, and more knowledgeable persons should educate them on what is best for them at the same time taking care not to influence the patient's decision making. And in order to do that, we should be competent in autonomy in making the right choice for treatment.

Although medical students spend years learning about physiology, anatomy, and biochemistry in a daily basis, there's still formal lessons through which students are taught fundamental leadership skills, such as how to lead a team, how to confront problematic employees, how to coach and develop others, and how to resolve conflict. The curriculum itself serves as an evidence that leadership qualities are important for a medical doctor.

Within the first few years after graduating medical school, or during houseman ship, houseman doctors in all specialties lead teams consisting of their junior residents, as well as other healthcare personnel, without undergoing any formal training or experience in how to manage teams. It is rare for first-year housemen to not becoming second-year housemen, and for senior residents not becoming fellows or attending physicians, although each step involves more management and leadership. And the span of leadership and responsibility grows bigger and wider once physicians enter independent practice.

I would like to enlighten all of you that one of the 5 domains of the Medical Leadership Competency Framework (MLCF) states that leadership means being able to work with others, and being a physician is not a solo sport. The healthcare system includes the collaboration of multiple teams and various departments. Acts of leadership can come from anyone in the organization, as appropriate at different times, and are focused on the achievement of the group rather than of an individual. Therefore, shared leadership actively supports effective teamwork as it affects the culture and climate you and your colleagues work in. Thus, affecting the experiences of patients and service users, the quality of care provided and the reputation of the organization. This fact can be further justified by a study published in 2014 by Dr Thelma Quince, proves that leadership and management skills are required to ensure the provision of high-quality patient care. Active participation of clinicians in leadership and management appears beneficial and positive associations have been found between doctors appointed to hospital boards of directors and clinical outcomes and overall performance.

In addition to clinical responsibilities, doctors frequently serve also as leaders and advocates at the individual, community, and societal levels; this is because medical doctors have for a long time held a special position in society. They are often in a unique position of insight and provide important and useful perspectives which are valuable even outside of the scope of medical practice. As respected members of the community-at-large, as well as key members of the healthcare system, doctors have the opportunity to get involved and make a difference at any and all levels. In order to fulfil this expectation of the public, we should be prepared with the valuable leadership quality needed in developing a cohort of future medical leaders to accede to these roles.

Many, if not most, of us as medical students will one day aspire to, or be thrust into, roles of leadership. Whether leading in the setting of clinical practice, research, academic industry, public health, or any other manner of leadership role, it is our responsibility to remember the pledges we have made to serve our patients to the best of our abilities. As medical students and

medical/health professionals we hold a privileged place in society, and such privilege comes with a degree of responsibility to the community and society we serve. We must therefore remember that in addition to training to become medical doctors, we should also be training to become leaders. Whether we like it or not - not to mention whether we are prepared or not - we will ultimately be put in roles of leadership. It is our responsibility to not take leadership lightly, and to prepare ourselves as best as we can. To be a physician is to lead.
Before I end my speech, I would like to reaffirm our stand for today.

**3RD SPEAKER: MR PREM KUMAR S/O ARIVANANDAN**
First and foremost, I would like to express my sincere appreciation and to convey my gratitude to Prof Soe Soe Aye for giving me this opportunity to speak today.

In his farewell address the president of the Association of American Medical Colleges, Jordan Cohen, MD, made this statement: "The doctor's professionalism is defined not only by what he or she must know and do, but most importantly by a profound sense of what the doctor must be." Well, I doubt that I have many things to say, as the previous proposition team speakers have given most of the solid, valid and crystal-clear points to support today's motion. Before I come to my own arguments, let us first have a look at what the opposition speaker had said. She claimed that junior doctors are the least experienced persons to demonstrate leadership in managing responsibilities. So, my question here is, aren't junior doctors the one who should accommodate these leadership skills in the long run which allows the healthcare providers to experience a development in the management of patients? According to WHO as stated in the operations manual for staff at primary health care centres, doctors who have these leadership qualities are a credit to the healthcare services they manage. Therefore, whatever she claimed and said is sadly untrue.

Moving on to my own argument, as the third speaker, let me start by telling you a little about the history of professionalism. In 1999, the Accreditation Council for Graduate Medical Education (ACGME) implemented general competencies, applicable to every specialty, that need to be imparted during residency or fellowship training. One of these six competencies is professionalism. The same year that professionalism was listed as an ACGME general competency, the Medical Professionalism Project was launched by the American Board of Paediatrics Foundation, the American College of Physicians Foundation and the European Academy of Internal Medicine. The result was a professionalism charter, which was published in 2002 and has subsequently been adopted by many major professional physician organizations. The professionalism charter defined three fundamental principles of professionalism which are the primacy of patient welfare, patient autonomy and social justice. Physicians can take these important principles and add the depth that is needed to apply them in their own settings. So, professionalism is an important component of medicine's contract with society. Not only do we need to make good decisions for our patients based on the evidence in the literature, but we need to apply those decisions in a way that is professional and ultimately helps our patient.

Next, according to the Hippocratic Oath, medical doctors usually after graduation take an oath to safeguard their patients from harmful and waggish activities, and such oath has been in practice since the time of Hippocrates. Hippocratic Oath guides the premier objective of the medical profession. It talks about not only obligations concerning the patient but also responsibilities headed for fellow colleagues of medicine. Overall, Hippocratic Oath discusses the medical professional's commitment to give comfort and relief and not to cause any kind of harm to the patient. Medical professionalism promotes the ethical and moral duties and

responsibilities of a doctor to his or her patients. Therefore, high standard of ethical principles and practice among physicians as individual are expected to form the bridge between doctors and the community.

Why is professionalism so important? The primary rationale for professionalism and collaboration is to promote patient safety. Health care is delivered by teams of professionals who need to communicate well, respecting the principles of honesty, respect for others and responsibility for their actions. Further, the working environment in health care comprises multiple learners, among them fellow physicians, residents and non-physicians, including students and patients. Apart from that, physician well-being is essential to their expression of their professionalism and capacity to provide compassionate and effective patient care.

The relationship between healthcare professionals and patient is intended to be therapeutic in nature as the patient has a need for technical services from healthcare professionals and the healthcare professionals are the technical experts who are qualified to help the patient. The ability for healthcare professionals to maintain the level of professionalism is very important because this will give assurance to the patients that they (patients) are in good hands. A healthcare professional should be able to supply a measure of support and the security of knowing what one is supposed to do. A healthcare professional has to find ways of handling various situations which enable them to continue to provide health care services. The patient who feels that the healthcare professional has been professional is comforted and assured. It is also important that the medical professionals should use the language that can be easily understood as jargons may work perfectly well with professionals but not with patients, thus creating confusion, misunderstanding and dissatisfaction in patient. Hence, professionalism can bring trust and confidence between the healthcare professionals and the patient.

Respected members in this platform, other than that, decision making in medical professionalism is vital as there are many other alternative treatments, and as a healthcare provider, we need to choose the right treatment that has the highest probability of giving an effective treatment to the patients. Decision-making is a process of reducing any uncertainty and doubt to allow a healthcare provider to choose the best choice among them. In a nutshell, a high standard of professionalism will benefit both healthcare providers as well as patients in the long run and it allows healthcare providers to experience a development in self-confidence together with reliance from patients, co-workers as well as, appreciation from others. Professionalism is a fulfilment for all patients, no matter young or old. It also behoves healthcare providers to serve in a proficient manner at all times because it creates a positive effect on every single individual involved in any circumstances. In other words, professionalism denominate the entire healthcare practices in aspects like communication and decision making by implementing the value itself onto the healthcare providers. Thus, it is essential for healthcare provider to be versatile and not to underestimate any one aspect of professionalism.

Ladies and gentlemen, before I end my presentation, let me briefly restate my main points again. Medical professionalism is important in terms of promoting patient's safety, giving assurance, trust and confidence as well as decision making in giving an effective treatment to the patients. I think the facts are crystal clear here. Remember, ladies and gentlemen, "in all debates, let truth be the aim, not victory or an unjust interest. Therefore, this house strongly upholds the stand for today's debate theme. With this I rest my case. Thank you.

**B. OPPOSITION TEAM 1ST SPEAKER: MR LOGITHASAN**

We, as today's opposition have structured our case as follows. I, as the first speaker, would like to talk mainly regarding the autonomy aspect.

So, as mentioned by the first speaker, the clinical work freedom is the most obvious type of autonomy. Of course, it refers to doctors' ability to determine whether to treat a patient without being restricted by corporate protocols, budgetary issues, performance assessment systems or management control. For example, control over decisions on which tests and examinations should be ordered, which medicines and procedures should be prescribed. But the task of the junior doctor is entirely different as they still do not have the privileges on these issues yet. Restrictions on such autonomy often define aggregated measures such as pre-set budgets, channel certain treatments through a gatekeeper or detect outliers with unusual treatment patterns.

Apart from that, I would like to add on my points of several main domains of autonomy that all the medical students are unable to demonstrate. It is followed by social and economic work freedoms, such as control over the nature and volume which represents doctors' ability not to be managed in the industrial sense but rather to determine their own movements, priorities, schedules and workloads. But of course, junior doctors do not have the ability yet to do so. Plus, another domain of autonomy that I would like to emphasize on is influence on organizational decisions. This refers to doctors' voices in organizational and managerial choices and their ability to influence the manner in which their unit and hospital function. And yes of course, the power to influence organizational and sub-unit decisions does not depend on the junior doctors but on senior doctors and other hybrid doctor-manager position.

Next, at medical school, we train by conducting systematic histories and examinations, prioritizing differential diagnosis, and independently formulating management plans for patients for education purpose to learn and we have the scope to explore many different specialties and opportunities for research and education. In a nutshell, I would like to strengthen our point, a junior doctor's work is absolutely different. The job autonomy of junior doctors may be limited at the beginning of residency. The trainees perceive little decision latitude in scheduling or how the tasks are done. Despite long and arduous hours spent committing large volumes of information to memory for exams, much of the day at workplaces is spent doing administration, documentation, and basic practical tasks such as phlebotomy. The opportunities for independent assessment, diagnosis, and management are relatively scarce, particularly early on in training. Moreover, from a study we have seen that job autonomy in workplaces especially for junior doctors has been found to have positive effects on psychiatric distress, depressive symptoms and job-related well-being for instance, job dissatisfaction and emotional exhaustion.

So, I would like to start my next point with a question". "What is meant by patient autonomy?". "Please let me explain". In this advanced era, the power gap between doctor and patient has dramatically been narrowed. The patient is an informed consumer, entitled to be educated about their illness and treatment options and, in most cases, to be the ultimate decision-maker on choice of the medical path that they wish for. Therefore, the doctors are no longer a benign or benevolent dictator, but rather facilitators of information and of a patient's decision-making process which largely focuses on partnering with, rather than instructing patients during the delivery of healthcare. A doctor and his or her patient should no longer be viewed as parent and child, but rather as collaborators in shared decision-making regarding healthcare. So, this is called the patient autonomy where the rights of patients to make decisions about their medical

care without health doctor's influence trying to change the decision. To respect patient autonomy, doctors must provide information without manipulation or coercion. In one study, nearly a third of junior doctors reported intentionally influencing patients to accept or reject procedures. On occasion, junior doctors struggle to respect patients' wishes about treatment while they may be aware of the patients' wishes, they may be unable to respect them when their superiors are unreceptive to the patient's requests. As junior doctors, we may not be autonomous in managing responsibilities for many decisions as significant as a move towards palliation of the patient. Hence, rather than all the junior doctors demonstrating competency in autonomy, we can accept that they might be deliberative in routine clinical situations. The doctors provide information, understand patients' values and help the patient in deciding to choose the best treatment option in the given situation. Here, the patient is clear about their expectations and values, and therefore, the doctor is like a friend, involving the patient in a discussion on which course of action would be the best. An ideal relationship does not vest the entire decision-making to either the doctor or the patient alone but a process of shared decision making with mutual participation and respect is ideal.

**2ND SPEAKER: MS KUNASANGGARI CHANDRASEKARAN**

Firstly, I would like to address what the second speaker of the proposition team has put, upfront in her speech. She mentioned that it is rare for first year house officers, not to progress to second year. That alone contradicts with the motion today. It is rare, but not impossible which still implies that there are some house officers who are not competent enough to progress to second year house officers.

Moving on to my point, leadership is indeed an acquired skill. But there is something to wonder, can every medical student acquire that skill? Even if they did acquire, can they demonstrate it at the right time, right place? As the speaker had defined, leadership is a skill to lead people or organization. This complex skill is an integration of skills like efficient time management, analytical thinking, effective communication and high degree of emotional intelligence. A research done in 2020 found that every student has the potential to lead, and that leadership skills must be taught. However not 100% students are going to acquire leadership skills. There are many challenges to inculcate leadership skills in students.

First and foremost, all skills require a certain amount of time, effort and most importantly experiences. Being a medical student, we spend most of our time studying, not forgetting the amount of time we spend planning, preparing and even worrying about studying. Not to mention the piles of assignments we have to complete along the course. It is a no brainer when medical students prioritizes academic instead of building soft skills. Students reported educational barriers relating to the often-overwhelming number of competencies they need to accomplish to progress through the undergraduate curriculum. The schedule leaves little time in which they can pursue skills like leadership and even less incentive to do so. Time is already stretched for students, with all the different workloads that they have to complete. I think there are so many pressures through medical school.At the end of MBBS course, medical students' transit into a new chapter as a house-officer. Being a junior doctor, other challenges may arise. As a junior doctor, what are we required to do? Let me tell you, junior doctor's responsibilities include making notes in patient's files, clerking, following ward rounds, requesting for blood test, making drug charts, making referrals to other departments, requesting for imaging and small procedure such as drawing blood throughout the day. Junior doctors have very limited opportunities to demonstrate leadership skills. All day every day they work on their clinical skills leaving them very little time to enhance their leadership skills. Do you possibly think that

junior doctors or house officers will be able to demonstrate competency in leadership amidst the tasks and responsibilities?

Moving on to my next argument. Medical students and house officers are the least experienced ones in healthcare field. We are still learners and there is so much we do not know yet. As medical students and junior doctors, we gain as much knowledge as we can. Medical officers and specialist consultants guide us throughout houseman ship. They guide us with knowledge, insights and their own experiences. How are we expected to demonstrate leadership as we are at the bottom of the hierarchy? Who can junior doctors guide? Junior doctors observe and learn and when they become medical officer, they can guide house officers beneath them. That is their time to demonstrate leadership skills. According to a journal about the effectiveness of a Malaysian House Officer (HO) preparatory course for medical graduates on self-perceived confidence and readiness published in 2020 reported the prevalence of anxiety and lack of readiness to work among HOs are similarly high which is around 60% - 64%. The lack of confidence and readiness among HOs may affect their wellbeing. Previous studies reported they were stressed, and many were emotionally burnt out. This can lead to extension of their posting, and sometimes even dropping out of the HO training all together. As mentioned earlier there are many HO preparatory courses available, however not many of them are held on a consistent and regular basis. Inadequate house officer preparatory courses also play an important role in molding students and fresh graduate in demonstrating competency in leadership after MBBS course. And for all these reasons, the motion for today, must fall. Thank you.

**3RD SPEAKER: MS KEISWINI**
We, the opposition team, believe that the Debate statement is false.

According to Epstein and Hundert (who conducted a research on defining professional competence in medical practice in 2002), defined professional competence as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served. The professionalism requirements of the Accreditation Council for Graduate Medical Education (ACGME) is that the residents are expected to demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development, then to demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices and lastly to demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

On the other hand, Calman who conducted a research on the profession of medicine, proposed the ‘key values’ expected of professional doctors include high standard of ethics, continuing professional development, ability to work in a team, concern with health as well as illness, concern with clinical standards, effectiveness and audit, ability to define outcomes, interest in change and improvement, and finally research and development.

As you can see the complexity of the definition and the concept of professionalism remains very vague for most medical students. Plus, the requirements of professionalism of the ACGME adds more complexity to the professionalism concept among medical students. So, just presenting students with lists of what is involved in professionalism may be daunting and

may lead to lack of interest. This will prevent them from showing competency in professionalism at the end of their MBBS programme.

According to research done by Epstein and Hundert on Professionalism in medicine and also research done by Khalid Altirkawi on Teaching professionalism in medicine stated that another hindrance faced by medical students in showing competency in professionalism is the so-called hidden curriculum. Even while a medical school or institution defines professionalism values, those in it, may at times model unprofessional characteristics and thus undermine the educational objectives. Students enter medical school with idealism, with a commitment to being good doctors, taking good care of patients, and being successful in the profession. Yet, they can begin to lose that idealism early on. Using an instrument that examines moral reasoning, researchers have shown that medical students finishing medical school have more cynicism than nursing students finishing nursing school. Thus, experiences during medical school seem to undermine some of the professionalism educators try to impart. Other examples of the effects of the hidden curriculum include students' tendency to detach from patients, more than is needed to maintain professional responsibility; their loss of reflection and a turning to routine actions based on expectations about what a physician in a particular specialty is supposed to do; their acceptance of hierarchy; and their identification with specialty-based modes of being a physician.

Coming to my final point, as students engage in their training in the clinical setting, the values of the medical profession are often instilled indirectly, through observation of the role models of the desired personal attributes. This mechanism of teaching is clearly no longer sufficient, and it cannot be relied upon for fostering professionalism in current trainees or students due to increased complexity of the healthcare delivery system.

Observation of negative role modelling by physicians in clinical settings will make them perceive professionalism as less important and prevent the medical students from showing competency in professionalism. Moreover, students also have negative role models from the media to contend with. In television shows like Grey's anatomy, House, M.D. and Scrubs, the physician characters often model unprofessional behaviours.

Madam Chairman, ladies and gentlemen, I strongly oppose today's motion due to various barriers faced by medical students to show competency in professionalism which are not easy to overcome and require ample knowledge and experience.
So do you think that all medical students have the ability to overcome all the hindrances and should be able to show competency in professionalism in managing responsibilities at the end of their MBBS programme, well if you ask me, I will definitely say 'NO'.

**DISCUSSION**
**REMARKS by PROPOSITION TEAM -MS KIERTHANA SHRI (after all three speakers had presented)**

In summary, our first speaker spoke about the importance of being able to demonstrate competency **in autonomy**. She said a medical student should demonstrate competency in autonomy because it will ensure the doctor's judgement concerning patient's treatment which is not affected by outside, non-medical factors such as organizational procedures, financial concerns, performance measurement systems, or any other managerial control. Furthermore, competency in autonomy is a fundamental principle of decision making. Decision making in

medicine is the ability to utilize professional judgment to make clinical decisions that best meet the needs of patients.

Moving on to what I had said. I said that all medical students should be able to demonstrate competency **in leadership** at the end of their MBBS programme to be able to work with others which contributes to better healthcare provided. Other than in the clinical setting, a doctor is also looked upon highly in a society and is expected to lead the community as a whole where and whenever necessary. To meet these expectations of the society, doctors should equip themselves with the key leadership qualities from the very beginning of their career as a doctor.

Then our third speaker said a medical student should demonstrate **professionalism** in managing responsibilities to promote patient safety, give assurance, trust and confidence as well decision making in giving an effective treatment to the patients.

Thus, I would like to reaffirm our stand for today. Thank you.

**REMARKS BY OPPOSITION TEAM- MR LOGITHASAN AND MS KUNASANGGARI CHANDRASEKARAN (after all three speakers had presented)**

There are barriers beyond the programmes that stifle and, in some cases, disempower junior doctors. One of the consequences of this is that medical career structures do not routinely expose doctors to leadership or operational management until they are deep into their careers, especially when compared to other professions. This means they do not get the opportunity to develop or demonstrate the wider leadership and management skills as they progress in their careers. The education and training programmes do not routinely identify management or leadership as a viable career objective and there is no recognised pathway for working towards becoming a leader. Programmes are very much oriented to developing expertise in a specialty and producing consultant or GP expert in their field. “As well as support is an issue, and I don't think in busy hospitals often have support to practise leadership.”

IN summary, Firstly, we conclude the following that clinical work freedom, social and economic work freedom and influence on organizational decisions is still not related to medical students at beginning of their residency. We also conclude that doctors holding managerial responsibilities, for example, senior doctors and other hybrid doctor-manager positions, identify with the organization more strongly than rest especially junior doctors because organizations give them more power in organizational decision-making, more complex responsibilities, and greater non-clinical autonomy as well. The autonomous role has changed dramatically as junior doctors have gone from being the lynchpin in the health care system to a devalued cog in a larger wheel. Secondly, a process of shared decision making with mutual participation and respect is ideal. Even in our short time as a 3rd year medical student in less than a year at Muar and Batu Pahat hospitals, we would have noticed this for sure. Thus, we can bring our medical training, evidence-based knowledge and expertise to the diagnosis and management of our patients’ condition and they will bring knowledge of their personal values and preferences to make the decision.

I, as the second speaker of opposition team argued how leadership have its own challenges to be inculcated in students, especially medical students. To sum up the gist, the quote by Vince Lombardi that goes “Leaders are made, not born” implies there so much thought process and actions that foster leadership skills. Wait, there is another bonus quote by Michael Jordan that goes Earn your leadership everyday which urge us to power through our everyday obstacles to

demonstrate leadership. My next argument was about house officers are the least experienced and not ready to work due to lack of clinical skills and interpersonal skills as well.

Our third speaker tried to tell you that there are many challenges such as understanding the complexity of the definition of professionalism especially in a constantly evolving healthcare system, secondly the so called hidden curriculum in which even while a medical school or institution defines professionalism values, those in it may at times model unprofessional characteristics and thus undermine the educational objectives and lastly observation of negative role model in clinical setting during their preclinical phase will prevent them from showing competency in professionalism in managing their responsibilities.

We, humans are perfectly imperfect. We have flaws and we make mistakes from time to time. It is unfair to expect ALL medical students to be competent at the end of MBBS course. In medicine, we may not do right things at the right time, and we may not know everything but that does not mean we do not have autonomy, leadership or professionalism. Yet it simply means we need to put in more time and effort in making ourselves better. Therefore, we strongly oppose the motion for today.

**REMARKS BY FACULTY**

The six speakers had spoken with vigor and passion upon the topic given for this debate. The BEST group was won by the Proposition Group and the BEST speaker was won by PREM KUMAR, A from the Proposition Group. It is true that leadership skills should be cultivated starting from medical school. As the saying goes, to bend bamboo while it's still a shoot. Also, we would like to add a quote by Douglas MacArthur, 'A true leader has the confidence to stand alone, the courage to make tough decisions, and the compassion to listen to the needs of others. He does not set out to be a leader but, becomes one by the equality of his actions and the integrity of his intent'.

**CONCLUSION**

Doctors simultaneously fill two overlapping but distinct roles: the *healer* and the *professional*. For the *healer* role, the Hippocratic Oath serves as the foundation of morality in medicine. The *professional* role, on the other hand, needs the framework within which to organize and dispense the services of the *healer*. "*A Physician Charter*" listed 10 professional responsibilities, grouped under 3 headings: Commitments to patients by the doctor as a *medical expert*: *Ethical* commitments to patient; Commitment as an *advocate* for society. In the Malaysian context, we see the role of Malaysian Medical Council in the discipline and perhaps remediation of errant medical practitioners. Universities, Academy of Medicine, Colleges within the Academy, Academy of Family Physicians and Specialist Societies play important roles, individually and collectively, in education and standard setting for undergraduates, post-graduates and practicing doctors.

We need many more doctors to actively participate in these processes of self-regulation.

**ACKNOWLEDGEMENTS**

We would like to thank the Dean (Acting) Faculty of Medicine, Asia Metropolitan University, the Adjudicators AP Dr Nay Lynn, Mr Cyril Deeben, Ms Puteri Maisarah, invited by the Principal Author Prof Dr Soe Soe Aye, Professor Head of Department of Paediatrics, the Year

3 Students who had participated in the Classroom Debate without whose efforts this publication would not have been materialized

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