Questionnaire survey for challenging cases of medical professionalism in Japan

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Abstract

Background: Little information is available on evaluation of medical professionalism among Japanese physicians and on its education in Japanese medical schools.

Aims: To assess professionalism and its education in Japan.

Method: We analysed the responses to challenges to professionalism for Japanese residents and physicians, using the Barry Questionnaire, and to survey the extent of education related to professionalism during medical school curricula. The survey was conducted at 14 teaching hospitals in Kyushu and Okinawa, using existing hospital conferences.

Results: We collected data from 175 participants (60 residents and 115 faculty physicians). The most challenging was the sexual harassment scenario, in which 51.4% provided the best or 2nd best answers, followed by the honesty scenario with 69.7% and the confidentiality scenario with 76.0%. Participants were more likely to provide the best or 2nd best responses to the scenarios involving physician impairment (87.4%), conflict of interest (81.1%), and acceptance of gifts (78.3%). Five (3%) participants reported learning experiences about professionalism during the curricula and the median hours for its course work were two hours. Only one resident reported that she was satisfied with these educational sessions.

Conclusions: Many Japanese physicians were unable to provide an acceptable response to challenges to professionalism in several issues and few had received education in professionalism during school curricula. Greater teaching of professionalism is needed in medical education in Japan.

Introduction

Medical professionalism is considered as the ability to meet the relationship-centered expectations required to practice medicine competently (Lynch et al. 2004). It is based on the principles of primacy of patient welfare, patient autonomy, and social justice (ACGME 2004). It generally involves the following responsibilities: competence; honesty; confidentiality; appropriate relations with patients; improving quality of care; improving access to care; just distribution of finite resources; commitment to scientific knowledge; maintaining trust by managing conflicts of interest; and commitment to professional responsibilities (Swick 2000; ACGME 2004; Williams 2005). Although there is debate on the definition for appropriate professionalism and still areas for non-consensus among its topics (Crueck & Crueck 2000; Lynch et al. 2004), a society grants much of the trust and respect to physicians because of the expectation of high standards of medical professionalism (Crueck & Crueck 2000).

US studies report that modern physicians encounter many challenges to medical professionalism in their everyday practices (McArthur & Moore 1997; Hall & Berenson 1998). However, the recent US study by Barry et al. (2000) using a questionnaire with challenging scenarios to professionalism, indicates that many physicians are not able to provide an acceptable answer to these challenging scenarios. Although medical educators continue their efforts to develop ways to teach professionalism, many US physicians also report that they are dissatisfied with their training in this area (Barry et al. 2000).

Recently, medical professionalism has also gained an increasing public attention in Japan (Koizumi 2006). Recent Japanese studies also report that Japanese physicians

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commonly encounter challenges to medical professionalism (Fukumoto 2006; Takeda & Cosgrove 2006). However, little information is available on evaluation of medical professionalism among Japanese physicians and on education for medical professionalism in medical schools. Although medical professionalism is a challenging area to assess (Cruess & Cruess 2000), it seems worthwhile to investigate the current state of this area in the Japanese medical environment. Thus, we aimed to analyse the responses to common challenges to medical professionalism for Japanese physicians and to survey the extent of education related to professionalism and satisfaction with it during the time attending medical schools.

**Methods**

We conducted a survey of physicians at several teaching hospitals in Kyushu and Okinawa, Japan, using the Barry Questionnaire (Barry et al. 2000). Permission has been granted for the use of this instrument (ACGME 2004). The questionnaire instrument contains 6 challenging cases to professionalism: acceptance of gifts; conflict of interest; confidentiality; physician impairment; sexual harassment; and honesty in documentation. Each scenario was followed by 4 or 5 responses.

After completing all six scenarios, participants were asked, ‘Have you ever experienced formal educational courses about medical professionalism’ on yes or no responses. If the answer to this question was yes, participants were then asked, ‘How many hours of course work devoted to professionalism did you take?’ and ‘Are you satisfied with contents of these educational sessions on yes or no responses’. We also collected data for specialty, gender, and work status (resident or faculty physician) of each participant.

Although we obtained a formal permission from 14 teaching hospitals, we could not receive mailing addresses for physicians due to the Japanese confidentiality rule for employees. Thus, rather than mailing a survey to potential participants, we used existing hospital conferences for implementing the questionnaire in these 14 hospitals. Those conferences were the regular staff conferences and were traditionally held on weekday mornings in most Japanese teaching hospitals. All participants were Japanese and they read and signed informed consent before the survey. Participants were assured of confidentiality and anonymity. All surveys were conducted in 2005. The study was approved by the Institutional Review Board of Okinawa Chubu Hospital, Okinawa, Japan.

The Barry Questionnaire was developed and validated in a study conducted in Colorado, USA by Barry et al. (2000). They performed the following steps to develop and evaluate the instrument: the scenario review was conducted by a panel of people with experience in medical ethics, clinical practice, or laws; the consensus on the ‘best response’ and the ‘second best response’ for each scenario was derived. We present each scenario of the Barry Questionnaire with the best response and the second best response in the Appendix. For the purpose of the study, we developed the Japanese version by translating texts and responses of the instrument into the Japanese language. Content validity of this Japanese version was confirmed by an independent panel comprised of physicians responsible for educational programs in 14 participating hospitals (educational committee, Muribushi Okinawa Residency Project) based on the contents of professionalism guideline of the Japanese Medical Association (JMA 2004).

We analysed the frequency of providing either the best or the second best answers to each scenario as a main outcome measure and compared those frequencies between physicians in training (i.e., residents) and faculty physicians. We also compared the main outcome measures of the current study to those of US physicians from the original study by Barry et al. (2000). The Fisher exact test and proportion comparison test with normal distribution approximation were used to analyse data, where appropriate. All statistical analysis was performed using SPSS-J 15.0 (Tokyo, Japan) and two-tailed p-value of less than 0.05 was considered as statistically significant.

**Results**

We collected data from a total of 175 participants (60 residents and 115 faculty physicians) during the conferences held in 14 teaching hospitals. There were 36 women (20.6%). Clinical specialty included internal medicine (n = 53), surgery (26), pediatrics (18), and others.

Table 1 compares the frequencies that the participants provided the best or 2nd best responses between student/resident and faculty physician. The frequency of either the best or 2nd best responses to the gifts scenario was significantly greater in faculty physicians than in students or residents (p < 0.001), while the frequency of either the best or 2nd best responses to the confidentiality scenario was significantly greater in students or residents than in faculty physicians (p = 0.001).

Table 2 presents the overall frequency that the participants provided the best or 2nd best responses for each scenario. The ranges of either the best or 2nd best answers to the six scenarios were 51.4% to 87.4%. Participants were most likely to provide the best or 2nd best responses to the scenarios involving physician impairment (87.4%), conflict of interest (81.1%), and acceptance of gifts (78.3%). The most challenging was the sexual harassment scenario, in which 51.4% of participants provided either the best or 2nd best answers,

Table 1. The frequency of the best or 2nd best responses for each scenario: Resident and faculty.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>(1) Resident (N = 60)</th>
<th>(2) Faculty (N = 115)</th>
<th>p-Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Conflict of Interest</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>0.998</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>0.001</td>
</tr>
<tr>
<td>Impairment</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>0.099</td>
</tr>
<tr>
<td>Harassment</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>0.874</td>
</tr>
<tr>
<td>Honesty</td>
<td>104 90.4</td>
<td>104 90.4</td>
<td>0.874</td>
</tr>
</tbody>
</table>

Notes: *p*-Values are estimated based on Fisher’s exact test.
followed by the honesty scenario with 69.7% and the confidentiality scenario with 76.0%.

Table 2 also compares our results to data of US physicians from the study by Barry et al. (2000). The frequency of either the best or 2nd best responses to the minor confidentiality (p<0.001) and sexual harassment (p=0.009) scenarios were significantly greater in US participants than in Japanese participants. However, the frequency of either the best or 2nd best responses to the gifts (p<0.001) and physician impairment (p=0.031) scenarios were significantly greater in Japanese participants than in US participants.

Among 175 participants, there were five (2.9%) participants (3 residents and 2 faculty physicians) who reported having received formal educational courses about medical professionalism. Among these five participants, the median hours for course work devoted to professionalism were two hours (range, 1–4 hrs) during the entire school curricula. Out of these five participants, one (20%) participants (1 resident) reported that they were satisfied with these educational sessions.

Discussion

Our results provide information on several aspects of medical professionalism among Japanese physicians. Many Japanese physicians were unable to provide an acceptable response to challenges to professionalism on several issues at a similar degree compared to US medical students and physicians. A substantial proportion of physicians in training and faculty physicians did not experience formal educational courses about medical professionalism in medical schools. Even among those with experience of the educational courses, the amount of its course work was relatively small and few participants were satisfied with them. These observations suggest that teaching of fundamental principles in medical professionalism needs to be among the important curricula for medical education in Japan.

Many Japanese physicians failed to provide an acceptable response to challenges to professionalism in several scenarios. Most of all, the frequency of the best or second best answers for the scenario concerning sexual harassment was the lowest and at only 51%. The recent Japanese survey for medical students also indicates that more than a half of women students experience sexual harassment at least once during clinical clerkships. The main sources of sexual harassment are physicians: very few reported to someone in authority (Nagata-Kobayashi et al. 2006). The concept of sexual harassment emerged only in the late 1980s in Japan and the government policy for its prevention was formulated for the first time in 1999 (Nagata-Kobayashi et al. 2006). Thus, Japanese physicians may have relatively low awareness of the importance and exact contents of this concept.

Further, the frequency of the best or second best answers for the scenarios concerning honesty and confidentiality were also relatively low, 70% and 76%, respectively. Moreover, the frequency of either the best or 2nd best responses to the confidentiality scenario was significantly greater even in students or residents rather than in faculty physicians. Japanese medical education may be partly responsible for these results. Since medical schools in Japan put little emphasis on clinical ethics, the teaching of these issues may not be adequate (Tokuda 1995, 1998; Tokuda et al. 2004). Greater ethical education may be needed urgently in Japanese medical practice to improve cognitive aspects of medical professionalism. In particular, the promotion of core faculty for teaching medical ethics in Japan may provide an opportunity as a role model in rewarding and fostering professionalism in medical school graduates (Shrank et al. 2004).

A substantial proportion of Japanese physicians did not experience the educational courses about medical professionalism in medical schools: even among those with experience of educational courses, the amount of its course work was small; few were satisfied with them. One US study suggests that the teaching of professionalism in undergraduate medical education varies widely in the US (Swick et al. 1999). Since professionalism concerns issues of behavior, ethics, values, and knowledge, there is an ongoing debate on how to teach and assess professionalism in medical education (Swick et al. 1999). Although most medical schools in the US now address this important topic in some manner, the strategies used to teach professionalism may not always be adequate (Swick et al. 1999). However, the study by Barry et al. (2000) indicates that satisfaction with training in professionalism is significantly related to the amount of course work which they had taken. Given the growing importance of medical professionalism in Japan, there may be a current need for the greater education in this subject.

There are strengths of the current study. First, this may be the first study to assess the state of medical professionalism among Japanese physicians. In the US, professionalism and its assessment across the medical education continuum have also become prominent topics during recent years (Hilton & Slotnick 2005). A broad scope of approaches to assessing professionalism is available and actively used in the US (ACGME 2004). However, there are few studies to date on this issue from Japan, although Japanese medical organizations recently recognize the importance of medical professionalism and biomedical ethics (Fukumoto 2006; Koizumi 2006; Takeda & Cosgrove 2006). Second, the Barry Questionnaire, which we used in the current study, addresses contemporary issues related to professionalism. The study by Barry et al. indicated that it is sensitive to different levels of experience; practicing

### Table 2. The frequency of the best or 2nd best responses for each scenario: Comparison to Barry study.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>N (%)</th>
<th>Barry (%)</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gifts</td>
<td>137</td>
<td>78.3</td>
<td>56</td>
</tr>
<tr>
<td>Conflict of Interest</td>
<td>142</td>
<td>81.1</td>
<td>85</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>133</td>
<td>76.0</td>
<td>86</td>
</tr>
<tr>
<td>Impairment</td>
<td>153</td>
<td>87.4</td>
<td>81</td>
</tr>
<tr>
<td>Harassment</td>
<td>90</td>
<td>51.4</td>
<td>61</td>
</tr>
<tr>
<td>Honesty</td>
<td>122</td>
<td>69.7</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Notes: *Only data of percentage are available from the study by Barry et al. (2000).*
P-Values are estimated by proportion comparison test with normal distribution approximation.

N/A indicates data not available.
physicians have performed better than residents who, in turn, have performed better than medical students, thus providing some evidence of construct validity (ACGME 2004). In addition, content validity of the Japanese version was confirmed by the contents of the professionalism guideline of Japanese Medical Association (JMA 2004).

There are potential weaknesses of the current study. First, our sample size was relatively small, compared to that of the study by Barry et al. (2000). Second, our data were obtained from medical students and physicians only in prefectures of Kyushu and Okinawa areas and it is uncertain to what extent these findings can be generalized to other areas of Japan. Third, we used existing hospital conferences for implementing the questionnaire, while Barry et al. (2000) used a mail survey. Participants to the conferences may have had more interest or knowledge in the subjects related to professionalism than non-participants. Thus, it may be possible that we obtained a biased sample. Fourth, the case scenario approach is not the only way to measure attitudes about professionalism, since it only addresses the cognitive aspects of professionalism (ACGME 2004). It could be better to combine another method that addresses professional behavior. Assessment of professionalism could also be performed through subjective, narrative, and personal approaches. Fifth, using only 6 vignettes, it addresses a limited scope of medical professionalism issues and there is no information about reliability (ACGME 2004). Sixth, while it would have been preferable to perform analysis stratified by age, years after graduation of medical schools, and practice settings, these data could not be obtained from the available database.

As another limitation of this study, the issues in the Barry questionnaires may be viewed differently by physicians of different cultures, since the Barry Questionnaire is developed on the US practice setting and culture, so that some scenarios may not be encountered commonly and could be viewed as acceptable behaviors in Japanese practice settings. Indeed, we, as surveyors, felt that Japanese participants in this survey displayed willingness to consider alternative ethical frameworks. Further research is needed for analyzing the difference of the detailed contents for professionalism between countries.

In summary, we found that many Japanese physicians were organized the survey and drafting of the manuscript. Y. Norisue, R. Konishi, and H. Kudo collected data and conducted the analysis. S. Miyagi organized the survey and supervised the study.

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References

ACGME. 2004. Advancing education in medical professionalism: An educational resource from the ACGME Outcome Project.


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Y. Tokuda conceived the idea, led the data analysis, and wrote manuscript. P.B. Barnett advised about the design,
Appendix: Barry Professionalism Questionnaire

Please read the following cases. Recognizing that there may be other approaches, select the single best answer from those listed.

1. A pharmaceutical company approaches you about a clinical research project involving your office patients. Your patients with high blood pressure will be eligible to be treated with a new medication that has just been released by the FDA. The object of the study is to evaluate risks and benefits of this medication in an unselected office population. The pharmaceutical company will pay $250 per patient for the expenses generated by the study, and one year’s salary for a data manager and will supply the drug free of charge. Meetings to discuss the initiation of the study and follow-up results will be held in New Orleans and Honolulu. Your spouse will be invited as the company’s guest to attend these meetings since they will take you away from home.

Participating in the study would be considered appropriate professional behavior if:
A. your patients signed an informed consent;
B. your patients sign an informed consent and your partners approve the study;
C. an oversight committee of the hospital where you have privileges or your regional medical society approves the study;
D. none of the above.

2. You are practicing hematology and oncology in a suburb of a large metropolitan area. Currently, you refer your patients who require radiotherapy to one or two hospitals in the city depending on where the patients live and the type of problem. A radiotherapist whose knowledge and skill you respect informs you that she will be joining a for-profit national radiotherapy company that is thinking of locating in your community. She informs you that an excellent opportunity now exists to invest in this company and that the larger the number of investors from the area, the greater the likelihood the company will locate the unit in your area.

Which of the following statements most accurately assesses the possibility of conflict of interest regarding your investment in this company?
A. An investment will pose a conflict of interest and you should not make it.
B. Your investment will pose no conflict of interest because the new radiotherapy unit will offer superior treatment and will be available to your patients.
C. There is a possibility of conflict of interest that requires that you inform your patients of the investment.
D. Your investment will pose no conflict of interest if you avoid referring your patients to the new radiotherapy unit.
E. There will be no problem of conflict of interest for you if the investment is made by your spouse.

3. A friend’s 16-year-old daughter visits your office requesting birth control pills. Her family is Catholic and against birth control and premarital sex. She requests you do not discuss this with her parents. After concluding the visit, you return to your desk where you find a message to call the patient’s mother. In the past you have always discussed the daughter’s health and concerns openly. What will you do?
A. Call the mother back and disclose the reason for her daughter’s visit.
B. Return the call and tell the patient’s mother you can’t discuss the matter, knowing this will look suspicious to her.
C. Return the call but be evasive when questioned about the nature of the visit.
D. Don’t return the call.

4. You are the chief of service at a hospital and a medical student informs you that she smelled alcohol on the breath of an attending physician during morning rounds on more than one occasion. This report is confirmed by another student and a resident. How do you proceed?
A. Approach the physician in question and ask if he/she has a drinking problem.
B. Talk to friend and family members of the physician to see if they suspect a drinking problem.
C. Review the physician’s file and monitor him/her closely.
D. Report the physician to the Colorado Board of Medical Examiners.

5. During your rounds with the housestaff team, a male staff member comes up to the group, places his arm around the waist of a female house officer, and thanks her for the terrific job she did taking care of one of his patients. You sense that the house officer is made uncomfortable by the gesture. An appropriate first response would be which of the following?
A. Do nothing, on the basis that the faculty member was simply showing his appreciation for a job well done.
B. Report the incident to the program director as an example of sexual harassment.
C. Tell your colleague, the faculty member, that you thought the gesture was inappropriate and that you were made uncomfortable by it.
D. Ask the resident if the gesture made her uncomfortable.
E. Ask the resident if there are actions she would like you take on her behalf.

(6) An established patient of yours presents with symptoms of depression. This is the second time in three months that the patient has visited you for these complaints. You wish to start treatment with anti-depressant medication. As you are filling out the prescription, the patient asks you not to document the diagnosis or medication in the chart. She is concerned that her employer will find out about her diagnosis and she could potentially lose her job like a coworker did. She knows that her insurance company has access to her diagnosis. How do you proceed?

A. Inform the patient that you must document the diagnosis to provide any treatment.
B. Agree to not document the diagnosis but prescribe the medication anyway.
C. Agree to not document the diagnosis but refuse to provide the prescription.
D. Terminate your relationship with the patient because she is inhibiting your ability to provide adequate care.
E. Document an alternative diagnosis, such as fatigue, and provide the prescription.

The best responses were D for scenario 1, A for 2, B for 3, D for 4, C for 5, and A for 6. The second best responses were C for 1, C for 2, C for 3, A for 4, E for 5, and C for 6.