Professionalism in Context: Insights From the United Arab Emirates and Beyond

Ming-Jung Ho, MD
Mohamed Al-Eraky, PhD

Over the past decades, professionalism education has become a key competency in the medical education continuum. The rising focus on professionalism has been paralleled by an increasing interest in competency-based medical education in graduate medical education globally. However, as professionalism reflects a contract between the medical profession and society, the definition of professionalism in globally accepted competency frameworks developed in Anglo-Saxon contexts may not reflect the societal expectations of other cultures.

In this issue of the *Journal of Graduate Medical Education*, Abdel-Razig and colleagues[1] reported a qualitative study to develop a locally derived consensus definition of medical professionalism for the United Arab Emirates (UAE). They used an innovative combination of methods, including world café, nominal group technique, the Delphi method, and interpretive thematic analysis. The main finding was that 9 professionalism attributes derived from their consensus definition overlapped considerably with known Western definitions. However, 3 important differences were noted: (1) the primacy of social justice; (2) the role of personal faith in guiding professional practices; and (3) the extension of professional attributes to personal life.

While the study of Abdel-Razig et al[1] is limited by the small number of participants, it invites us to consider professionalism beyond Arab cultural contexts. The study concludes that the definitions of professionalism and the contract between the society and the profession made up of expectations and obligations between both parties should be relevant to local, social, and cultural contexts.[2] For decades, Western models[2] have been adopted as the benchmark for conceptualizing professionalism globally. Yet the study by Abdel-Razig and colleagues[1] serves as an important reminder that these models may not be applicable to non-Western cultures. For instance, the third attribute not found in Western frameworks (the extension of professional attributes to personal life) resonates well with the traditional role of Arab physicians, as they are expected to act as community leaders, not only as health providers. Studies of stakeholders' expectations of professionalism from Taiwan and China that report the influence of Confucian values also support the argument that, when it comes to the definition of professionalism, one size does not fit all.[3]

Furthermore, although some elements of professionalism are informed by universal humanistic values, interpretations vary across cultures. For instance, an aspect of humanism is respect for patients. However, different interpretations of these values are evident in aspects of medical practice, such as varying physician-patient relationships. For example, in Western models the interpretation of respect emphasizes patient autonomy, in which patients make their own medical decisions. In contrast, paternalistic models convey respect to patients by entrusting physicians to make decisions, as professionals, on behalf of patients. For instance, Arab physicians are perceived as "masters" who are supposed to know and decide what is best for their patients; they are perceived to lack confidence if they express diagnostic uncertainty.[4,5] This paternalistic model of patient care is not exclusive to the Arabian context, and is also reported in studies from Pakistan,[6] Ughanda,[7] Malaysia, and India.[8] These models are based on different interpretations of humanism, specifically respect toward patients, in comparison to models prioritizing patient autonomy.

The study by Abdel-Razig et al[1] invites us to pay attention to the roles of faith, values, and history in shaping professionalism in various cultures. Studies from Japan, Taiwan, and the Arab world support these roles. For instance, the 7 virtues of Bushido, a Japanese code of personal conduct originating from the ancient samurai warriors, have been used to interpret professionalism in Japan.[9] In Taiwan and China, Confucian values, including integrity,[5] morality,[10] and relationalism,[11] are reflected in the perception and practice of professionalism. In an Arabian context, the Four-Gates Model[12] conceptualizes professionalism at 4 levels (gates) of professional conduct while dealing with (1) self, (2) task, (3) others, and (4) God. There is some overlap between

DOI: http://dx.doi.org/10.4300/JGME-D-16-00103.1

the findings reported by Abdel-Razig et al[1] and the Four-Gates Model. Both frameworks acknowledge the role of faith and relationship with God, where excellence, lifelong learning, integrity, and accountability are interpreted as the Arabic concepts of *Ehsan*, *Etqan*, *Taqwa,* and *Ehtesab*. These findings invite us to consider the role of faith in shaping medical professionalism, by providing practitioners with an internal compass to navigate his or her path in a sophisticated health care environment, even in the absence of direct supervision or immediate reward.

Since professionalism is context-specific, can we map patterns of professionalism for each region or culture? It is tempting, however if we do, we are in danger of stereotyping cultural groups and ignoring the diverse subcultures within a region. Take Gulf countries, for example, where the expatriate populations from various national and cultural backgrounds are almost equal or, in some cases, even larger than the local population.[13] It is risky to apply cultural theory based on the elusive "national culture," as it may not reflect the needs of expatriates from various cultural backgrounds. Studies from Taiwan and China, which share common cultural roots, have reported differential conceptualization of professionalism,[10,14] and warn us not to assume that similar cultural groups have the same professionalism expectations. We suggest that readers interpret findings reported by Abdel-Razig et al[1] with caution, so as not to overlook the cultural diversity of Arab countries. Further research into professionalism in culturally diverse societies is needed to assist with the development of frameworks that reflect this diversity.

Furthermore, teaching professionalism in a cosmopolitan society like the UAE is challenging because many health practitioners are expatriates from different cultural origins. Practitioners need to reflect on how their native, deeply held values and beliefs influence the care they provide and their own expectations about health, illness, patients, and their families. As in the idiom, when in Rome, expats have to do as the Romans do, but also Romans should help the visitors.[15] In other words, hospitals and care settings where expatriates practice should include cultural orientation programs to explicitly communicate the norms, customs, values, and expectations of patients in the host societies and provide platforms for expat physicians to reflect and reconcile the conflict between host and native professionalism standards.

As medical educators we have to develop a culturally sensitive professionalism framework[16] at the institutional level that will form what Cruess and Cruess[17] call the *cognitive base*. This framework, which will guide trainee teaching and assessment, should be based on clear expectations of professionalism. Commonly, professionalism is broken down into a list of desirable *attributes*[2,12,14] or expected *behaviors* that can be observed, measured, and assessed.[18–21] However, checklists of attributes and behaviors may not fully capture the desired competencies of professionalism. We propose, in its stead, a more nuanced approach whereby attributes are thought of as macro-level elements of professionalism and behaviors as micro-level elements. We also suggest adding an intermediate, or meso-level, in the form of competencies or entrustable professional activities (EPAs).[22,23] This intermediate level is missing, not only in the Abdel-Razig et al[1] study, but also in the majority of studies on medical professionalism.

Professionalism competencies can be used to guide curriculum development. Tsai and colleagues[21] reported how the National Taiwan University integrated key competencies of professionalism longitudinally within existing curriculum through innovative teaching methods. These methods included forums with patient advocacy organizations to enhance students' understanding of local health needs.[24] In addition, when discussing clinical scenarios, descriptions of competencies can assist teachers and students to assemble behaviors and attributes, displayed as pieces of a jigsaw puzzle, into a full picture of a professional practitioner. Setting culturally sensitive professional *attributes*, *behaviors*, and *competencies* at the institutional level also facilitates formative assessment within each educational experience throughout the entire program, which is in line with societal expectations of professionalism.

In conclusion, Abdel-Razig and colleagues[1] contribute to our understanding of professionalism by demonstrating a combination of innovative methods to produce a definition of professionalism reflecting Arab culture. These methods can be employed to develop definitions of professionalism in different cultures. As medical educators, we have the responsibility to develop culturally sensitive professionalism frameworks that do not stereotype cultures, but rather take into account the diversity of patient and practitioner cultures within national contexts.

References

1. Abdel-Razig S, Ibrahim H, Alameri H, Hamdy H, Haleeqa KA, Qayed KI, et al. Creating a framework for medical professionalism: an initial consensus statement from an Arab nation. *J Grad Med Educ*. 2016;8(2):165–172.
2. ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical

professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243–246.
3. Ho MJ, Yu KH, Hirsh D, Huang TS, Yang PC. Does one size fit all? Building a framework for medical professionalism. *Acad Med*. 2011;86(11):1407–1414.
4. Morrow G, Rothwell C, Burford B, Illing J. Cultural dimensions in the transition of overseas medical graduates to the UK workplace. *Med Teach*. 2013;35(10):e1537–e1545.
5. Jha V, Mclean M, Gibbs TJ, Sandars J. Medical professionalism across cultures: a challenge for medicine and medical education. *Med Teach*. 2015;37(1):74–80.
6. Humayun A, Fatima N, Naqqash S, Hussain S, Rasheed A, Imtiaz H, et al. Patients' perception and actual practice of informed consent, privacy and confidentiality in general medical outpatient departments of two tertiary care hospitals of Lahore. *BMC Med Ethics*. 2008;9(1):14.
7. Baingana RK, Nakasujja N, Galukande M, Omona K, Mafigiri DK, Sewankambo NK. Learning health professionalism at Makerere University: an exploratory study amongst undergraduate students. *BMC Med Educ*. 2010;10:76.
8. Yousuf RM, Fauzi AR, How SH, Rasool AG, Rehana K. Awareness, knowledge and attitude toward informed consent among doctors in two different cultures in Asia: a cross-sectional comparative study in Malaysia and Kashmir, India. *Singapore Med J*. 2007;48(6):559–565.
9. Nishigori H, Harrison R, Busari J, Dornan T. Bushido and medical professionalism in Japan. *Acad Med*. 2014;89(4):560–563.
10. Ho MJ, Yu KH, Pan H, Norris JL, Liang YS, Li JN, et al. A tale of two cities: understanding the differences in medical professionalism between two Chinese cultural contexts. *Acad Med*. 2014;89(6):944–950.
11. Ho MJ, Lin CW, Chiu YT, Lingard L, Ginsburg S. A cross-cultural study of students' approaches to professional dilemmas: sticks or ripples. *Med Educ*. 2012;46(3):245–256.
12. Al-Eraky MM, Donkers J, Wajid G, van Merrienboer JJ. A Delphi study of medical professionalism in Arabian countries: the Four-Gates model. *Med Teach*. 2014;36(suppl 1):8–16.
13. Gulf Labour Markets and Migration. GCC: Total population and percentage of nationals and non-nationals in GCC countries (latest national statistics, 2010–2015). http://gulfmigration.eu/total-population-and-percentage-of-nationals-and-non-nationals-in-gcc-countries-latest-national-statistics-2010-2015. Accessed February 16, 2016.
14. Pan H, Norris JL, Liang YS, Li JN, Ho MJ. Building a professionalism framework for healthcare providers in China: a nominal group technique study. *Med Teach*. 2013;35(10):e1531–e1536.
15. Al-Eraky MM, Marei HF. Medical professionalism: when in Rome,... Romans should help visitors. *Med Teach*. 2016;38(2):214.
16. Ho MJ. Culturally sensitive medical professionalism. *Acad Med*. 2013;88(7):1014.
17. Cruess RL, Cruess SR. Teaching professionalism: general principles. *Med Teach*. 2006;28(3):205–208.
18. Nath C, Schmidt R, Gunel E. Perceptions of professionalism vary most with educational rank and age. *J Dent Educ*. 2006;70(8):825–834.
19. Al-Eraky MM, Chandratilake M, Wajid G, Donkers J, van Merrienboer J. Medical professionalism: development and validation of the Arabian LAMPS. *Med Teach*. 2013;35(suppl 1):56–62.
20. Blackall GF, Melnick SA, Shoop GH, George J, Lerner SM, Wilson PK, et al. Professionalism in medical education: the development and validation of a survey instrument to assess attitudes toward professionalism. *Med Teach*. 2007;29(2–3):e58–e62.
21. Tsai TC, Lin CH, Harasym PH, Violato C. Students' perception on medical professionalism: the psychometric perspective. *Med Teach*. 2007;29(2–3):128–134.
22. ten Cate O, Chen HC, Hoff RG, Peters H, Bok H, van der Schaaf M. Curriculum development for the workplace using Entrustable Professional Activities (EPAs): AMEE Guide No. 99. *Med Teach*. 2015;37(11):983–1002.
23. van Loon KA, Driessen EW, Teunissen PW, Scheele F. Experiences with EPAs, potential benefits and pitfalls. *Med Teach*. 2014;36(8):698–702.
24. Tsai SL, Ho MJ, Hirsh D, Kern DE. Defiance, compliance or alliance? How we developed a medical professionalism curriculum that deliberately connects to cultural context. *Med Teach*. 2012;34(8):614–617.

Ming-Jung Ho, MD, is Assistant Dean for International Affairs, Vice Chair, School of Medicine, and Professor, Department/Graduate Institute of Medical Education & Bioethics, National Taiwan University College of Medicine, Taipei, Taiwan; and **Mohamed Al-Eraky, PhD,** is Assistant Professor, Medical Education Department, College of Medicine, University of Dammam, Saudi Arabia.

Corresponding author: Ming-Jung Ho, MD, National Taiwan University, No. 1, Section 4, Roosevelt Road, Da'an District, Taipei City, Taiwan 10617, mjho@ntu.edu.tw