Differences in the perceived importance of professional behaviors in academic and clinical settings from an alumni survey of a Japanese medical school

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Purpose: Medical professionalism is an important component of medical education. This study was conducted to investigate professional behaviors as perceived by physicians.

Method: A self-administered questionnaire was mailed to graduates of a private medical university. Respondents rated the importance of 24 professional behaviors using a 5-point scale along two dimensions: importance of the behavior being taught at school (academic setting) and importance of practicing the behavior as a physician (clinical setting).

Results: Of 3,188 alumni, 417 (13.1%) responded to the survey. Mean age was 46.3 years, and 71.9% were male. The most important behavior for both dimensions was confidentiality of patient information. Significant differences in responses between academic and clinical settings were found in 19 of 24 behaviors; of them, 4 items were rated as more important in the academic setting than in the clinical setting and 15 items were rated as more important in the academic setting than in the clinical setting. No differences between settings were found for 5 items. Low scores were seen for not falling asleep in conferences and for demonstrating appropriate boundaries with pharmaceutical company representatives.

Conclusions: These findings demonstrated that the perceived importance of professional behaviors is different between the academic and clinical settings. A future study should aim to improve medical education on professionalism by exploring the content of professional behaviors in more detail.

Key words: Professionalism, physician, medical student, alumni

I Introduction

In 2002, a physicians’ charter proposed the three principles for medical professionalism in the new millennium – primacy of patients’ welfare, patients’ autonomy, and social justice – as well as 10 professional responsibilities. These principles vary across cultures, traditions, and societies, although there are certain common themes¹. Among various definitions, Arnold and Stern stated that, “professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical and legal understandings, upon which is built the aspiration to and wise application of the principles
of professionalism: excellence, humanism, accountability, and altruism” (19). This has been widely accepted and referenced.

In response to this, the Japan Society for Medical Education held the 16th meeting of the Ethics and Professionalism Committee and issued a statement on the need to introduce professionalism in both undergraduate medical education and lifelong learning. The Japanese medical education core curriculum was revised accordingly in 2016, and begins with the 10 fundamental abilities and capacities of a physician. As stated in the first section of this updated curriculum, professionalism is a substantial factor.

The introduction of medical professionalism in Japanese medical schools occurred around 2010. A previous study reported that only 15% of medical schools specifically listed professionalism in their curricula as of February 2012. Another study examined recognition of a physicians’ charter among Japanese and American physicians, and found that overall, only 30% of physicians surveyed had knowledge and understood the context of a physicians’ charter. Therefore, ongoing effort is necessary for implementing a physicians’ charter and professionalism in Japanese medical education.

A further study used focus groups to qualitatively investigate the non-medical population’s perception of the medical profession, and found five themes: primacy of patient welfare, fairness, social responsibility, maintaining appropriate relations with industry and with patients, and agreement with a physicians’ charter. In sum, medical professionalism is a multidimensional construct for physicians, patients, and society.

Professionalism should address not just definitions, but also implementation and evaluation. Fitness to practice has been used to investigate professionalism among medical students. Fitness to practice and professional behavior are both described in the booklet of guidance for medical students published by the UK’s General Medical Council and Medical Schools Council. Although this booklet was prepared specifically for medical students, including a list of dos and don’ts, some items are equivalent to those specifically directed at physicians. Though the National Board of Medical Examiners provides an assessment of professional behaviors to evaluate physicians in training (2007, 2013), few references are available for measuring professionalism.

The present study was conducted to investigate the professional behaviors of physicians, along with the relative degrees of importance of these behaviors, during both school and clinical practice among alumni of a private medical school.

II Methods

Subjects were alumni of Dokkyo Medical University who graduated between 1979 and 2011. A questionnaire was mailed together with the alumni newsletter and a self-addressed stamped envelope in January 2012.

To develop the questionnaire, we reviewed previous studies and selected two references. The first was an assessment developed by the National Board of Medical Examiners in the US and consisted of 59 items evaluated by the frequency of each behavior displayed by observees. The other had 36 behaviors originally characterized by Japanese researchers who served as medical advisors. The first one was translated into Japanese, after which four researchers— including two experienced clinical professors—carefully examined the translation, discussed both assessments, and chose items to assess professional behaviors for the present study. Next, a draft survey was preliminarily tested using several volunteer graduates, resulting in a final version that contained 24 questions. After that, we presented the survey to the board of alumni associ-
ation. Among the board members were graduates with many years of clinical experience; they approved and agreed to mail the survey to the school’s alumni. The study was approved by the ethics committee of the faculty of Dokkyo Medical University.

As the subjects graduated before 2011 and did not receive any formal education on professionalism while at medical school, the survey asked them to rate the importance of each item along two dimensions: importance of the behavior being taught at school (academic setting) and importance of practicing the behavior as a physician (clinical setting). Items were scored on a Likert scale from 1 (not important at all) to 5 (very important). Subjects were also asked about the first time they became aware of the importance of medical professionalism.

Demographic information (gender, age, marital status, working status, workplace, and field of specialty) was also collected. The survey was anonymous and took approximately 10 minutes to complete.

Data were analyzed using IBM SPSS version 25. A reliability coefficient (Cronbach’s $\alpha$) of the questionnaire was calculated, and the Wilcoxon signed rank test was used to compare whether an individual rated the same item differently in each dimension.

### III Results

A total of 417 graduates responded to the survey (response rate, 13.1%). Table 1 presents demographic characteristics of the respondents. There were 300 men (71.9%) and 117 women (28.1%), mean age was 46.3 years, 82.0% were married, and most (92.3%) were working full-time at the time of the survey. Almost half of respondents were employed at a medical institution (50.6%), and the other half were self-employed (46.8%). Specialties were varied; the largest number was in internal medicine (22.1%), followed by ophthalmology (8.2%), and orthopedic surgery (6.5%).

Table 2 shows when alumni first became aware of the importance of professionalism for physicians. The most common response was during their time as an intern or a resident (N=158, 37.9%), followed by after beginning work as a doctor (N=73, 17.5%), before entering medical school (N=66, 15.8%), and during clinical training (N=56, 13.4%).

Table 3 lists mean scores of 24 professional behaviors in the academic and clinical settings. The reliabilities of this questionnaire were 0.920 (academic) and 0.888 (clinical). There were significant differences in 19 questions. Among them, 4 items (8, 11, 12, and 14) were rated to be more important in the academic setting than in the clinical setting, and 15 items (3, 4, 5, 6, 7, 9, 10, 13, 16, 17, 18, 20, 21, 23, and 24) were more important in the clinical setting. No significant differences were found for 5 items (1, 2, 15, 19, and 22). The highest score for both dimensions was seen for item 1, “maintains confidentiality of patient information”. The lowest score for the academic setting was item 21, “demonstrates appropriate boundaries with pharmaceutical company representatives”, and the lowest score for the clinical setting was item 14, “does not fall asleep in conferences or meetings”.

### IV Discussion

Professionalism is an important factor in medical education. However, its implementation at Japanese medical schools had a slow start relative to implementation in the US and Europe. While teaching medical professionalism is now commonplace, there have been few studies on specifically which professional behaviors were regarded as important by licensed physicians. Therefore, this study aimed to identify the degree of importance of professional
behaviors in order to aid further education on professionalism. We found that 19 of 24 behaviors were rated differently in the two settings by doctors already working in the field. As physicians working in the field have already recognized and are implementing medical professionalism, these 15 behaviors were considered more important in the clinical setting than in the academic setting. An interesting finding was that four items were regarded as more important behaviors in schools than in actual practice, which are all in line with expected fitness of practice of students: arriving in time for

| Table 1  | Demographic characteristics of respondents (N=417) |
|----------|---------------------------------------------------|
| Gender   | Male 300 (71.9%)                                   |
|          | Female 117 (28.1%)                                 |
| Age (mean ± S.D.) | 46.3 ± 8.8                                      |
| Marital status |                                             |
|           | Single 58 (13.9%)                                 |
|           | Married 342 (82.0%)                                |
|           | Separated 1 (0.2%)                                 |
|           | Divorced 12 (2.9%)                                 |
|           | Widowed 4 (1.0%)                                   |
| Work status |                                             |
|           | Full-time 385 (92.3%)                              |
|           | Part-time 30 (7.2%)                                |
|           | Leave of absence 1 (0.2%)                          |
|           | Not indicated 1 (0.2%)                             |
| Workplace |                                             |
|           | Employed 211 (50.6%)                               |
|           | Self-employed 195 (46.8%)                          |
|           | Academia 7 (1.7%)                                  |
|           | Not indicated 4 (1.0%)                             |
| Specialty (top four fields) |                                          |
|           | Internal medicine 92 (22.1%)                       |
|           | Ophthalmology 34 (8.2%)                            |
|           | Orthopedic surgery 27 (6.5%)                       |
|           | Gastroenterology 20 (4.8%)                         |

| Table 2  | When respondents became aware of the importance of medical professionalism |
|----------|---------------------------------------------------------------------------|
| Period   | N (%)                                                                     |
| Before entering medical school | 66 (15.8%)                   |
| Upon entering medical school  | 8 (1.9%)                     |
| During medical school (first to fourth year) | 42 (10.1%)                   |
| During clinical training (fifth year) | 56 (13.4%)                   |
| During internship or residency | 158 (37.9%)                   |
| After working as a doctor (after internship and residency) | 73 (17.5%)                   |
| Not yet aware | 12 (2.9%)                    |
| No response | 2 (0.5%)                    |
At the start of activities, meeting deadlines for documents, dressing appropriately with good manners, and not falling asleep in conferences/10).

In our study, item 12 of the questionnaire focused on appropriate appearance, manner, and way of speaking and was rated as being more important in the academic than in the clinical setting. In general, young people, including students, are allowed to wear casual clothes and use an informal way of speaking, while doctors are required to act with a higher level of sophistication and professionalism than students. Thus, this finding was contrary to our expectations because teaching manners and appropriate use of language to students has been regarded as an important part of medical professionalism training and education. It is presumed that doctors become less careful about their appearance as they become more experienced.

Moreover, previous studies have reported that a doctor’s attire has a significant influence on patients in establishing comfort, trust, and satisfaction/14-16). Thus, doctors should be more cognizant

| Behavior                                                   | Academic Mean | Clinical Mean | Z score |
|------------------------------------------------------------|---------------|---------------|---------|
| 1. Maintains confidentiality of patient information        | 4.84          | 4.86          | 0.686   |
| 2. Washes hands prior to medical examination for infection prevention | 4.42          | 4.39          | 0.926   |
| 3. Provides better and safer medical care                  | 4.58          | 4.69          | 3.459 **|
| 4. Establishes a relaxing and attentive atmosphere during examinations | 4.02          | 4.28          | 5.575 ***|
| 5. Takes patients’ wishes and values into account when deciding treatment | 4.10          | 4.29          | 4.359 ***|
| 6. Conveys information to patients in a manner likely to be understood (e.g., language, speed) | 4.33          | 4.52          | 4.680 ***|
| 7. Asks questions to confirm patients’ understanding of information provided | 4.14          | 4.34          | 4.827 ***|
| 8. Arrives in time for start of activities (e.g., conferences, meetings) | 4.62          | 4.40          | 6.043 ***|
| 9. Composes appropriate written communications (e.g., reference letter) | 4.24          | 4.32          | 2.208 * |
| 10. Accurately enters information into medical records      | 4.76          | 4.82          | 2.430 * |
| 11. Meets deadlines for documents                          | 4.41          | 4.31          | 2.537 * |
| 12. Dresses appropriately and uses a formal way of speaking with good manners | 4.44          | 4.34          | 3.067 **|
| 13. Remains calm in difficult situations                   | 4.13          | 4.42          | 6.803 ***|
| 14. Does not fall asleep in conferences or meetings         | 3.68          | 3.35          | 6.856 ***|
| 15. Listens actively and shows empathy with patients        | 4.15          | 4.16          | 0.397   |
| 16. Demonstrates appropriate boundaries with patients       | 3.96          | 4.06          | 2.687 **|
| 17. Takes responsibilities for his/her medical practice     | 4.57          | 4.73          | 5.433 ***|
| 18. Acknowledges limits of his/her own medical knowledge, technique, or ability | 4.14          | 4.54          | 8.625 ***|
| 19. Shows initiative for learning the latest medical information | 4.34          | 4.40          | 1.654   |
| 20. Provides medical care with caution to avoid medical incidents | 4.47          | 4.73          | 7.348 ***|
| 21. Demonstrates appropriate boundaries with pharmaceutical company representatives | 3.55          | 3.73          | 3.938 ***|
| 22. Discusses and shares medical knowledge and skills with coworkers | 4.11          | 4.13          | 0.657   |
| 23. Seeks assistance when workload is too heavy            | 3.73          | 3.83          | 2.448 * |
| 24. Encourages communication and exchanges opinions with team members | 4.08          | 4.28          | 5.532 ***|

*p < 0.05, **: p < 0.01, ***: p < 0.001
of the importance of clothing at work; in particular, it is controversial whether a white coat should be worn at hospitals\(^{17-21}\). In 2008, the UK’s National Health Service advocated a new dress code of “bare below the elbows” in hospitals to facilitate better hygiene and infection control\(^{22}\). Despite knowledge that white coats are a possible vector for disease transmission, patients in England still prefer doctors with white coats\(^{23}\). Researchers in Japan have also found that patients most preferred doctors in a white coat\(^{17,19,20}\), and a separate study reported that medical students were most influenced by observing other physicians’ attire at work than by school policy or dress code\(^{24}\). Although there is no official dress code for doctors, there is an appearance guideline for hospital employees at our adjunct hospital. Despite the trend among some doctors in Japanese hospitals to wear scrubs rather than the traditional white coat, physicians should act as role models for medical students by being more attentive to their professional attire.

In this study, “demonstrates appropriate boundaries with pharmaceutical company representatives” (item 21) was rated as having a low degree of importance for both academic and clinical settings. Miyata investigated 5,431 Japanese medical students, and stated that a majority of fifth- and sixth-year students had already come into contact with a pharmaceutical company representative, receiving promotional stationery and participating in promotional lectures and seminars with company-sponsored meals\(^{25}\). These behaviors are very common for physicians, and the frequency of contact tended to increase as careers progressed\(^{26}\). Gifts and meals have been often argued to present a possible conflict of interest in medical research\(^{27}\). Another study found an association between pharmaceutical industry-sponsored meals given to physicians and an increase in prescriptions for those companies’ products\(^{28}\). Although some physicians tend to underestimate the influence of the pharmaceutical industry on their prescribing behavior, the relationship of physicians with drug companies begins as early as medical school. Thus, the importance of medical professionalism as it relates to this behavior should be emphasized more strongly in education, as early as possible.

Maintaining confidentiality of patient information had the highest mean score for both academic and clinical settings in this study. While this is well valued and recognized, camera-equipped smartphones and social media raise new concerns for confidentiality and privacy. Previous studies have shown that medical students and residents have used social media and posted unprofessional content\(^{29,30}\). There has been no such research on Japanese medical students concerning the unprofessional use of social media, though one report listed 20 cases of unprofessional behavior on Twitter, Facebook, blogs, or in e-mails among students in the medical field and health professionals\(^{31}\). Inappropriate and unprofessional use of social media is now common across members of a whole generation. Therefore, ongoing and up-to-date education on social media and confidentiality should be included in medical education.

It should also be noted that the curriculum at Dokkyo Medical University had very little or no effect on the results of this study. A required course called “Current Medical Ethics and Welfare”, which includes lectures on medical professionalism, was added to the curriculum in April of 2012; no similar classes existed prior to that time. This study was conducted in January of 2012, and the age of the subjects ranged from 25 to 62 years, meaning that none of our subjects ever took this class.

The limitations of this study should be recognized. First, the results are not generalizable, as this study concerned alumni of only a single private
medical school, and had a low response rate (13.1%). One reason for the low response rate might be that the questionnaire was sent with an alumni newsletter and therefore may not have received the desired level of attention, resulting in a failure to complete and return it. This also suggests possible selection bias because those who responded had higher interest in medical professionalism and education. Consequently, this might have led to overestimation in the results. Second, it should be noted that the medical specialties of the subjects in this study were slightly different from the data on specialty names according to a survey of medical institutions and hospital report conducted by the Japanese Ministry of Health, Labour and Welfare. At hospitals, the three main specialties were internal medicine, rehabilitation, and orthopedic surgery, whereas at clinics, they were internal medicine, pediatrics, and gastroenterology; ophthalmology was the second most popular specialty in our study. Third, our data were not analyzed by age or gender, and some items may break down differently according to these factors. Finally, there is no information from the subjects regarding postgraduate professionalism training and/or education that might have influenced the results.

Certain professional behaviors may need to be revised to reflect changes in social expectations over time; social media and smoking in particular will be taken into consideration in a future assessment. Smoking among physicians should be prohibited even though the smoking rates among the Japanese population at large as well as among members of the Japan Medical Association have decreased over the past decade. In 2016, 30.2% of men and 8.2% of women in Japan smoked, while 10.9% of male and 2.4% of female physicians out of a total of 5,583 smoked. At present, 1 out of every 10 male physicians still smokes. Additionally, issues relating to secondhand smoke and research funded by the tobacco industry have become topics of concern. Thus, not smoking is an important professional behavior, and should be included in professionalism training and education.

V Conclusion

This study examined the importance of professional behaviors in academic and clinical settings. The results demonstrated that most behaviors differed significantly according to setting, suggesting that the professional behaviors perceived as important by physicians differed between academic and clinical settings. For the advancement of effective education on medical professionalism, additional investigation will be needed to clarify the specific contents of professional behaviors.

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和文抄録

目的：今日の医学教育の中で、医師としての自覚や責任を伴うプロフェッショナリズムは重要な課題である。本研究では、医学部卒業生を対象に医師の適切な行動の重要性について項目ごとに調査した。

方法：関東にある私立医大卒業生を対象に、同窓会報とともにプロフェッショナリズムに関する自記式アンケート調査を同封した。アンケート回答の所要時間は約10分、無記名で返送された。結果：アンケートを送付した同窓生計3,188名のうち、417名（回収率13.1％）から回答を得た。回答者の平均年齢は46.3歳、男性71.9％、女性28.1％であった。勤務状況は常勤者が92.3％、非常勤のみ7.2％、また、勤務医50.6％（N=211）開業医46.8％（N=195）となっていた。なお、勤務医・開業医ともに内科医が最も多かった。

医師としてのプロフェッショナリズムを自覚した時期は、臨床研修期間（37.9％）が最も多かった。さらに、「医師のプロフェッショナリズムを教育するのに」及び「日頃医師として仕事をする上で」いう2側面から24の行動の重要度を、1～5点の5段階評価をした結果、ともに最高点（大変重要）を得たのは、「患者について守秘義務を遵守する」であった。24項目中19項目について有意差が認められ、うち4項目は教育上、15項目は医師として仕事する上でより重要となっていた。一方、「会議、学会、カンファレンス等にて居眠りをしない」「医師として製薬会社の社員等と適切な境界線を保つ」は2側面ともに得点が低かった。

結論：医師としての行動様式について医大卒業生を対象に調査をした結果、医学教育の現場と、実際に医師として仕事をする上での重要度に違いがあることが示された。今後は、医師のプロフェッショナリズム教育の実践の指標となる、医師の適切な行動内容について更なる研究と検討が望まれる。