Chapter 9
Modern Medical Professionalism

Abstract In this chapter, I will examine whether or not medical professionalism should take the same form worldwide. Japan has its own culture and ethos, both of which have significance in the clinical setting. However, if a Japanese doctor graduated from a Japanese medical school which is not accredited by international (Western) standards, then the doctor will not be able to work in the USA after 2023. Japanese medical schools are concerned about international standards because "Professionalism" is one of key part of accreditation. However, the question remains: should medical professionalism be measured in a universal and internationally standardized way? How would, for example, Japanese medical schools teach their medical students about the concept of autonomy, for which so many interpretations are possible? (see Chap. 3).

Further, I will explain the difficulties of teaching medical professionalism to medical students and young residents. In this chapter, I present two actual cases to illustrate these points. I bring to this discussion a case of medical professionalism using the Fukushima nuclear power plant accident as an example. Specifically, I question whether physicians are obliged to stay in an area highly contaminated with nuclear radiation. I also discuss whether one's obligation as a physician might require them to provide care during disasters. This is a different type of discussion about medical professionalism from those focused around clinical ethics.

Finally, I examine the happiness of the healthcare professional, a subject that has received little attention in the literature thus far in any country. I argue that the happiness of the healthcare professional should also be an important part of medical professionalism.

9.1 The Diversity of Medical Professionalism

How does culture affect the diversity of medical professionalism, and how much of this diversity should be acknowledged or accepted?

A. Akabayashi, *Bioethics Across the Globe*,
https://doi.org/10.1007/978-981-15-3572-7_9

In 2002, several authors from Western nations published the Physician Charter. This Charter presented three fundamental principles (the principle of primacy of patient welfare, the principle of patient autonomy, and the principle of social justice) and ten professional responsibilities.

In September, 2010, the Educational Commission for Foreign Medical Graduates (ECFMG) in the USA announced that eligibility requirements for the examination to receive a physician's license in the USA restrict the pool to those who graduated from medical schools that are accredited to international standards, and that this accreditation should be mandatory after 2023. That said, in order to be accredited internationally, Japan must meet the standards of medical education set by Western nations. This created pressure, as revealed by the following statement issued in 2014 by the Ethics/Professionalism Committee Chair of the Japan Society for Medical Education: "At this point, medical schools nationwide are increasingly active in their movement toward international accreditation. In order to be accredited, they must fulfill the standards of medical education in Western nations; 'Professionalism' is one of the requisite items for medical education outcomes in the West."

The Physician Charter was translated into Japanese soon after publication, as were the Casebook on Human Dignity and Human Rights (UNESCO, Casebook Series, No. 1, 2011) and the Casebook on Benefit and Harm (UNESCO, Casebook Series, No. 2, 2011).

The "Clinical Ethics Education Package" (2016) published by the Japan Society for Medical Education has a thorough list of educational tools that looked remarkably Westernized. The core curriculum by the Ministry of Education, Culture, Sports, Science and Technology (revised in 2016) is shown in the footnotes. This curriculum is also "globally standardized."[1]

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[1] Ministry of Education, Culture, Sports, Science and Technology
Medical Education Division, Higher Education Bureau
Core curriculum for medical education
Revised in 2016
A. Basic credentials/skills required of a physician
A-1. Professionalism
The physician must be thoroughly aware of their path of duty as a physician to protect others' health and be deeply involved in preserving human life. While practicing patient-centric medical care, they must work to master their role as a physician.
A-1-1. Medical ethics and bioethics.
Aims: To learn the importance of ethics in medical care and medical research.
Learning objectives: (1) To be able to present an overview of the historical flow of medicine and medical care and understand its meaning. (2) To be able to present an overview of ethical issues associated with clinical ethics, as well as issues related to life and death. (3) To be able to present an overview of the ethical rules established, including the Hippocratic Oath, the Declaration of Geneva, Physician's Occupational Ethical Guidelines, and the Physician Charter.
A-1-2. Patient-centric perspective.
Aims: To protect the secrets of the patient and their family, and while fulfilling one's duty as a physician and upholding medical ethics, prioritize patient safety above all else, constantly taking a patient-centric stance.
Learning objectives: (1) To be able to explain the basic rights of the patient as set forth in the Declaration of Lisbon on the Rights of the Patient. (2) To be able to explain the significance of the

Meanwhile, the Ottawa Conference (2010) emphasized the need to consider cultural context [1]. The general principles developed at this conference stipulate that "Professionalism is a concept that varies across historical time periods and cultural contexts." The sixth principle states, "Professionalism, and the literature supporting it to date, has arisen predominantly from Anglo-Saxon countries. Caution should be used when transferring ideas to other contexts and cultures. Where assessment tools are to be used in new contexts, re-validation with attention to cultural relevance is imperative." (p. 356)

The authors of the Physician Charter are all from the USA and Europe, so naturally, they depend on Western paradigms. In order to align Japan's standards with international standards, how should the Principle of Patient Autonomy, for example, be taught to medical students in Japan? As I explored in Chap. 3, the concept of autonomy in Japan differs markedly from that of the West, so is it appropriate simply to translate this and use it for education? Young medical students may interpret the principle of patient autonomy to mean that the physician should do whatever the patient asks within the bounds of clinical acceptability. However, is this the physician figure that is truly required in Japan's culture of *omakase*? Therefore, I wonder how much of this diversity should be acknowledged or accepted in medical professionalism.

In Japan, medical humanities education uses films and video educational resources. Those from English-speaking nations include "DAX's Case," "Discussions in Bioethics," "Awakenings," and "Patch Adams."

There are many different film educational resources in Japanese which take a different perspective, several of which are described below:

- *Ikiru* (To Live): (Director, Akira Kurosawa). This film was awarded the Special Prize of the Berlin Senate at the 4th Berlin International Film Festival in 1954. *Ikiru* grapples with the theme of receiving a cancer diagnosis. While the current discussion surrounding diagnosis disclosure is nearer resolution, at the time the film was presented, a diagnosis of cancer was not disclosed to patients. Its modern-day implications remain, however, as the viewer is able to view how the main character lives the remainder of his life. As such, it remains a highly valuable educational film.

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patient's right to self-determination. (3) To be able to understand the patient's values and advise them accordingly, even in instances where various options are available, supporting the patient's self-determination. (4) To be able to explain the significance and necessity of informed consent and informed assent.

A-1-3. Duty and discretion as a physician.

Aims: To act with compassion and a deep awareness of the dignity of life and be aware of one's duty as a physician to protect human life and health.

Learning objectives: (1) To become capable of constructing trusting relationships with patients and their families in the clinical practicum for participatory medical examination. (2) Recognize that the values and social backgrounds of patients and their families can be diverse and be capable of responding flexibly to any and all of these. (3) To be able to explain why physicians must recommend the most suitable medical care for the patient. (4) To be able to explain that physicians are limited in their diagnosis and treatment depending on their own skills and the environment. (5) To be able to recount one's legal obligations as a physician and demonstrate these in practice.

- *Akahige* (Red Beard): Directed by Akira Kurosawa. This film was awarded the San Giorgio Award at the 26th Venice International Film Festival in 1965. *Akahige* remarkably reflects the saying, "Medicine is a benevolent art." This phrase reflects a long-held concept in medical ethics and is consistent with the Hippocratic Oath. In other words, it centers on paternalism.[2]
- *Okuribito* (Departures): Directed by Yōjirō Takita, this 2008 film was awarded the Best Foreign Language Film at the 81st Academy Awards. The film features an encoffiner as the main character and portrays a very uniquely Japanese perspective on corpses.

Overall, "To Live," "Red Beard," and "Departures" are all very moving films. Why did these movies win international awards? They are somewhat paternalistic and exotic for foreigners, and very Japanese. How did they impress a foreign audience?

Once again, Japan uses its unique path to obtain "international accreditation." I feel that this is acceptable, because the primacy of patient welfare remains intact. In educational settings, I teach that the Hippocratic Oath is still important. This is because the term "paternal" includes the concept of "benevolence," which remains an important value. If medical caregivers lack a sense of being "for the patients" in their professionalism, then what patient will come to receive medical treatment? In addition, regardless of the national culture, if medical caregivers lose this major concepts of practice, then where are they to place their occupational identity?

Overall, as long as the medical professional curriculum includes the principle of primacy of patient welfare, the principle of patient autonomy, and the principle of social justice, then sufficient diversity might be preserved.

9.2 Difficulties in Teaching Medical Professionalism to Young Students and Residents

At 20 years or older, medical students are all adults, and very few are likely to change their moral sensitivity or moral reasoning as a result of their medical education [3].

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[2] "Medicine is the art of human-heartedness" is a phrase defined by the *Kōjien* (the mainstream Japanese dictionary) as "medicine is a benevolent/philanthropic road to save human life." It was used quite frequently, particularly during the Edo period, but the philosophical foundations are said to date back as far as the Heian period. Kaibara Ekiken (1630–1714), a Confucian scholar during the Edo Period (1603–1868), wrote the following in his "*Yojokun*" based on Confucianism [2]:

> Medicine is the art of human-heartedness. A physician should build the foundation of his practice on human-heartedness and love, both of which focus on helping others. His intentions should not focus on his own profit and welfare. As this is an art of aiding people—who have been given their birth and nourished by Heaven and Earth—and takes charge of their life and death, you could say that a doctor is one of "humanity's officials." This is an extremely important position.

Teaching professionalism to medical students and young physicians is very difficult. Let me share an experience from 1985 when I was a Chief Resident at a general hospital with 400 beds in a rural area and was in charge of two first-year residents and one second-year resident [4].

Scenario One
A first-year resident A, who was in charge of a terminal female cancer patient with hepatoma in her 60s, was facing his first experience of a patient's death as an attendant physician. Her breathing became weaker and weaker and her blood pressure started to drop… A couple of days before, I had instructed him about how to tell when she had passed….by checking her corneal reflex, heartbeat, and respiration, and then to give the precise time of death to the patient's family. On that day, her husband, children, and relatives were with her, waiting for her last moments. The patient ECG monitor became flat. Suddenly, the resident started cardiac massage and asked a nurse to prepare adrenalin for intracardiac injection. I was a bit upset and after a few seconds, whispered to him not to do any more. In response, the resident answered "But Dr. Akabayashi, it is a physician's duty to do everything possible! I must do this." He performed the injection and continued cardiac massage despite my instructions to the contrary. After several minutes of attempted resuscitation, one of the family members firmly requested, "Doctor, please stop." Then I held the resident's arm and made him stop the massage.

Scenario Two
A male patient in his 70s with terminal pulmonary emphysema. He had been unconscious and on a respirator with a tracheostomy for more than 2 months. The attending physician was a second-year resident B. Because of malnutrition, hypoalbuminemia, and longtime bed rest, his face was awkwardly edematous, and according to his family, he looked like a totally different person. The patient had been aggressively treated every time he developed respiratory or urinary infections….Since B was in his second year, and was a competent practitioner, he did not need the detail of the treatment regimen to be intimately supervised. (Here I mean, the choice of drugs, content of infusion, and the setting of respirator.) One day, I suggested to him that he should talk with the patient's family, and discuss and reassess the patient's treatment plan. I also expressed my opinion that the treatment should be less aggressive. In response, B replied, "But Dr. Akabayashi, the patient does not have any malignant disease!" The treatment was continued as before, and the patient died about 3 months later.

There was no particular obligation for me to intervene with the resident's decision in either case. Their acts were not illegal. All I could say was that they prolonged life in an inappropriate way. Today, 30 years later, we no longer encounter these situations.

When should one intervene with a doctor in training's decision-making? I can think of only two situations when intervention by a physician in training is permissible, or even required. The first is when an action of a colleague is clearly violating the law. The second is when an act is against established hospital policy.

Medical training remains a type of apprenticeship. During the training period, young physicians need to learn the technical skills necessary to treat patients, but this is only part of their medical training. They also need to learn the skills that will enable them to resolve the complicated problems of medical practice. Those skills, I would argue, stem from an education in medical professionalism.

The value most sought after by Japanese people after World War II was longevity. Today, Japan leads the world in terms of mean life expectancy. From the 1970s through the early 1990s, physicians assumed a stance that prioritized longevity over QOL. Palliative care had yet to be developed. Medical professionalism at the time comprised, at the very least, primacy of patient welfare as interpreted by the physician, in other words, paternalism. Medical professionalism would change according to the change of the goals of medicine. By 2050, other forms of medical professionalism will have developed. Thus, I conclude that medical professionalism must differ by era and region. The most important objective of medical professionalism is for medical personnel to be always concerned about what is best for the patient (specifically, to align to the goals of medicine in temporal and regional context).

9.3 Emerging Issues in Medical Professionalism

Let us consider an emerging problem in medical professionalism. In what follows I consider patient welfare, patient autonomy, and social justice. However, it is "professional responsibility" that may be the most applicable principle in this discussion.

In the *Cambridge Quarterly of Healthcare Ethics*, the section editors for Professionalism discussed my articles in their Introduction: A Modern Version of an Ancient Question, as follows [5].

> With remarkable candor, Dr. Akira Akabayashi acknowledges that he responded to a colleague's request for his ethical opinion on this question from the relative safety of Tokyo, when the question involved the professional commitment of a physician just outside the official 20-kilometer evacuation zone surrounding the damaged nuclear reactors at Fukushima. His commentary has a vividness that approaches the drama of real-time deliberations and ends with a note of uncertainty…
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> Nevertheless, their survey is helpful in placing Dr. Akabayashi's article in a historical context that extends far earlier than the outbreak of SARS, to which Dr. Akabayashi turns in a search for reflection and precedent. We would like to extend to our readers an invitation to respond in future issues of the *CQ* Professionalism section to the questions Dr. Akabayashi has posed, and that, as he suggests, continue to present challenges for bioethicists.

In my article, "Must I stay? The Obligations of Physicians in Proximity to the Fukushima Nuclear Power Plant," I question whether a physician is obliged to care for their patients if doing so would mean that they themselves are risking danger [6] (open access).

Case Dr. N's Request to Leave

In a hospital located a little more than 20 km (evacuate zone) from the affected nuclear reactors. I was asked the following question by the director of the hospital:

"a young female physician, Dr. N, wants to go home to Hiroshima, but we don't have enough physicians at the hospital. If she leaves, there will be no one to take care of her patients and the evacuees. What should we do?"

Dr. N argues that: "My parents are pleading with me to come back home to them in Hiroshima. I have a family that needs me. What are you going to do for me if I can't have any more children because of this? I can't continue treating patients under threat of contamination. I have the right to escape. Indeed, the Americans are evacuating, aren't they?"

Does Dr. N have a duty to remain, despite her reasons for leaving? Her superiors insisted that she stay, but does she have an obligation to comply? Should the hospital demand that she remain treating her patients?

9.4 On the Happiness of Medical Caregivers

I will conclude with a discussion that is often overlooked in publications on medical professionalism, and medical ethics. That is, what does happiness means to the physician (or medical caregiver)? Many articles discuss the obligations and responsibilities of physicians, but this issue is hardly ever addressed [7].

When teaching, I ask my students to consider that the core ethical question is, "what defines better medical care?" and "what comprises a better patient/medical caregiver relationship?" Indeed, medicine should be practiced in such a way that the medical caregiver is constantly thinking about the best possible benefit for the patient. However, in recent medical care settings, due to the collapse of the medical

care system and the existence of "monster patients" (those who make serious complaints or who are verbally or otherwise abusive), it is also the case that medical caregivers who have been scarred by past incidents are in situations involving an unforeseeable future. The collapse of the medical care system in Japan has come at the end of rapid developments in modern medicine. Burdens, therefore, are currently shouldered by overworked medical caregivers, among whom depression is common and rates of suicide are increasing. This medical care setting does not represent an environment in which medical caregivers have the time and space to always work in their patients' best interest

The question therefore remains: What is needed for medical caregivers to be happy? A word of thanks issued from a patient is said to be one of the best things to make medical caregivers happy. In addition, the feeling that health workers and doctors are healing diseases, removing pain, and are contributing something to the patients and to society undoubtedly serves as support.

However, even if we begin with Aristotle's Nicomachean Ethics and eudemonism and continue with more contemporary work concerning happiness theory, in particular drawing on Alain [8], Russell [9], and Hilty [10], we must look at happiness in a wider context.

At this historical moment, at its basis, happiness among medical caregivers is borne from the relationship between patient and caregiver. However, in the future, this may change as new ethical issues emerge. However, as long as the human race continues medical care will exist, and thus ethics in medicine will be necessary. In addition, regardless of the era, even in the era of artificial intelligence-based medicine, medical personnel must "heal and save patients."

I would like to leave the reader with a last idea. Namely, proper consideration of "the happiness of the medical caregivers" will expand the breadth of medical professionalism, with broad implications for the future.

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