Training Medical Professionals in Japan and the US:

Changing Medical Education Curricula

To Dr. Naoki Ikegami

Thank you. I hope I have written a good thesis.

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When the Same Symptoms Present: An Introduction

Two patients identify with a similar set of symptoms, and each visits the doctor. One patient stands outside a clinic in the early morning, while the other patient sits in a waiting room with one of the first scheduled appointments of the day. Despite one patient's free access to care, and the other patient's slot in a micro-managed appointment system, both patients wait two hours to see the physician. By the end of the appointment, the doctor acknowledges the reported illness, but it remains chronically unidentified.

It would be safe to assume that the reader of this thesis has at one point played the role of a patient and visited the doctor for a particular illness. As a patient who navigates the healthcare system, he or she is not unfamiliar with present issues in the healthcare system of his or her country. In fact, patients navigating healthcare systems in other nations, particularly Japan, are experiencing the same types of situations and encounters as patients in the United States. This is happening at a time when medical education, for the first time in a century, is actively making changes to its curricula. When defined by licensure, the practice of professional medical care has only existed in Japan and the United States for approximately one hundred and thirty years.

This thesis and its argument will reinforce the importance in comparing biomedicine in Japan and the US,[1] not because they are the same system, but because the same symptoms continue to present within these differing systems, much like a recurring illness. After a brief introduction to current topics in healthcare for these two nations, this

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[1] Both nations have been compared in scientific literature as early as the 1970s in an effort to synergistically improve healthcare.

thesis will reveal the origins of biomedicine as a professional practice in Japan and the

United States that is less than two hundred years old[2]. There is some evidence to suggest

that during this change, the licensure and professional status of physicians at the end of

the nineteenth century has had lasting effects on healthcare today, specifically by creating

an abstracted concept of what it means to be a professional.[3] Medical training of

physicians has perpetuated a doctrine governed by "professionalism," a sense of

appropriate manner, a qualitative measure that has since been quantified. Even so, since

the concession of physicians as licensed professionals and the standardization of medical

education, only now are medical schools adjusting curricula for future physicians. Now

that medical education is changing, this thesis will caution against the use of subjective

definitions of professionalism when teaching future physicians and will propose four

suggestions for changing curricula. Ultimately, this thesis will explore the

"professionalism" of professionals in healthcare and compare medical education curricula

in Japan and the US through preliminary research in Japan and unstructured interviews

with physicians in the US. The main objective of this thesis is to address the conundrum

of professionals being unaware of their own "professionalism."

Professionalism

The Charter on Medical Professionalism was concurrently published in 2002 in

both the *Lancet* and *Annals*. The publication, preceding this thesis by over a decade,

outlines three principles and a set of responsibilities that are entrusted to medical

physicians as professionals. Physicians become professionals after receiving appropriate

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[2] Biomedicine trains professionals to diagnose and to heal. It wasn't until the early twentieth century that physicians were able to cure many infectious diseases (small pox, malaria, etc.) that plagued society, despite the fact that the profession came into its own with the ability to diagnosis in the nineteenth century.
[3] A person engaged or qualified in a position that involves prolonged training and formal qualification.

training and subsequent licensure, with the ultimate product of their service as the becoming of a trusted individual for patients. To define professionalism, the Oxford American Dictionary defines the term as the competence or skill expected of a professional,[4] which is a rather subjective description for such a weighted topic. The argument of this thesis identifies professionalism as the underlying complexity in healthcare's relationship with society, and the Physician Charter, which explicitly recognizes that "professionalism is the basis of medicine's contract with society," adequately supports this original idea.[5] What is more, in other scholarly articles professionalism is equated to various other concepts, including appearance and attitude, competence, appropriate behavior, ethical conduct, patient interaction, communication, and, the most technical, acquisition of licensure.

Addressing professionalism makes the subjectivity of the concept clearer, and recognizing the potential consequences of the abstraction of this concept is the next revolutionary step in improving healthcare and patient care, the altruistic purpose of the profession to begin with. It is possible that healthcare issues continue to become more complicated because professionals are unable to assess the consequences of their own professionalism, past and present.

Chronically Unidentified Illness

Overall, biomedicine is a very broad topic to argue. To narrow the subject further, aging populations, health insurance and government spending are three examples where physicians face many complexities and professionalism is stretched thinly. These same issues, discussed for decades on how to improve a comprehensive system of healthcare

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[4] Oxford American Dictionary, *see professionalism.*
[5] Harold C. Sox, "Medical Professionalism in the New Millennium: A Physician Charter," *Annals of Internal Medicine* 136, no. 3 (2002) : 244

delivery, never leave the conversation; the issues only appear more complicated. That is

to say, literature in the healthcare world continues to discuss these issues as issues,

stoking the awareness for change, but clearly not admitting to have identified the illness.

Awareness of an issue is better than not realizing that one exists, and it is often

that problems are defined by their consequence; problems can really only be

acknowledged once they have reared themselves as such, or have been reared.

Complementarily, regular amendments to policy ought to be commonplace. In all

attempts to isolate the main issues in the system, most conclusions are in agreement that

navigating both the success and the foundering of the nations in healthcare is an

inevitable and unifying long-term responsibility on the behalf of healthcare authorities.

For instance, various works by Naoki Ikegami focus on positive and negative lessons

around policy making in Universal Health Care (UHC), not only for developing nations,

but also developed ones.[6] Amidst these attempts it is guaranteed and by some preferred

that changes to healthcare come incrementally and at a relatively steady pace. While

these amendments and lessons continue to adjust healthcare in the long-term, perhaps the

more recent changes occurring in the medical training of physicians can revolutionize

healthcare in the short-term by focusing on the activity of professionals in the field. As

healthcare issues seem to take more complicated forms, addressing professionalism in

medical education now is a necessary approach to take, and a parallel to the Physician

Charter in 2002. The following discussion will review three relevant topics where

healthcare issues have increased in complexity for both Japan and the United States, in

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[6] Naoki Ikegami and Akiko Maeda, overview to *Universal Health Coverage for Inclusive and Sustainable Development, Lessons From Japan,* ed. Naoki Ikegami (Washington DC : International Bank for Reconstruction and Development / The World Bank, 2014), 11.

order to give context to the theatre where medical curricula are changing and impact on

professionalism abounds.

The Aging Patient

Among the most pertinent of issues addressed in scientific literature is the aging

demographic in Japan and the United States. Aging society has significant influence on

health insurance and government spending. Furthermore, populations are aging

simultaneously within healthcare systems that some authorities might consider aged

themselves. Likewise, biomedicine is changing simultaneously with a standard of

medical training that has not changed in over the past century. Whether generalized by

diversity in the US or a comparable homogeneity in Japan, the vertical demography of

society is changing for both countries, and aside from the elderly, this has greater

implications for other participants in health care and the rest of the population. It has the

power to influence the coverage and resources available to other patients in the healthcare

system, while also mismatching resources and elderly patients.

> The demography of society is changing in all sorts of ways... The demands
> within families have changed – the burden of looking after elderly family
> members for many more years than was the case twenty years ago puts
> pressures on lifestyles and finances…There is a danger that currently
> aging members of a population will divert resources from the next
> generation, at the risk of increasing that generation's health problems. We
> have seen how many of the problems of health in middle age have their
> origins in early life and this demands resources. But these resources are
> increasingly needed for the elderly. Addressing the mismatches associated
> with ageing is a real conundrum.[7]

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[7] Mark Hanson and Peter Gluckman, *Mismatch: Why our World No Longer Fits our Bodies* (Oxford : OUP, 2006), 192-93.

One such mismatch associated with the aging population is that life expectancies are hitting record highs. According to World Bank data from 2014, the percentage of Japan's population over the age of 65 is 26%, which is nearly double the United States', a growing 14% of the population.[8] What is more, Japan's Ministry of Health, Labor, and Welfare announced in 2015 that the life expectancy of women hit a world record high at an average 86.83 years of age, with men taking the third spot globally at 80.50 years.[9] With these data it is an obvious conclusion that a significant portion of the population is getting larger and living for longer. One could argue that an ameliorative factor here could be the health of the Japanese population, which experiences less chronic conditions and represents a smaller number of individuals with HIV/AIDs, but another trend is remaining constant. Although Japan also has a high healthy life expectancy averaging over 70 years of age,[10] the margin between a healthy life expectancy and average life expectancy is not shifting to accommodate the increase in life expectancy; life expectancy in Japan increases, and the age of onset for limitations to health is remaining constant.[11]

With health compromised by limitations, resources for care are always needed for the aging population, especially in the United States. Yet, even with resources available, the US struggles with an appropriate application of these resources. Just as with Japan, elderly often have little to no income compared to middle-aged individuals, but will spend comparatively the same amount of money, if not more, on health care. When the

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[8] The World Bank. 2014. World Development Indicators. Washington, D.C., data for population ages 65 and above % total.
[9] "女性 86.83 歳で３年連続世界一　14 年の日本人平均寿命," *日本経済新聞*　July 30, 2015.
[10] 村上義孝. "平均寿命だけがどんどん延びていったら……," *朝日新聞* March 4, 2016.
[11] 村上義孝. "平均寿命だけがどんどん延びていったら……," *朝日新聞* March 4, 2016

elderly do have appropriate coverage and care, the delivery of care is still compromised. Edward Shorter recounts in his work, <u>The Health Century</u>, the common experience of a young physician who must provide care to many elderly patients in an emergency setting in limited amounts of time with each patient, often resulting in important details specific to geriatric patients being overlooked. It is not uncommon for such patients to have "multiple medical problems and very little understanding about them" while taking "fifteen different medications [with] no idea what they are and for what purpose."[12] These are the implications behind the aging population that training physicians encounter today, and one such example where the responsibilities of professionalism are tested.

The aging demography is affecting the medical and financial spheres of society, where a lack in elderly care, when filled, has the potential to compromise the health of the next generation in regard to the economy and resources. Even when care is accessible, it is not always appropriately matched to the patient. A connection between managing healthcare systems and understanding patient needs and how to meet them with the appropriate resources holds more weight than before. Aging patients represent a shared burden in Japanese and American society that holds greater implications. In both cases, a majority aging population is receiving a minority of the active focus of the biomedical system. Choosing to refocus on patient skills in medical education is a fortunate result of recent changes to curricula.

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[12] Edward Shorter, *The Health Century*, (New York : Doubleday, 1987), 219.

Another discussion correlated with the previous is one of national health insurance. The Japanese government nationally covers health insurance, whereas the United States capitalizes health insurance. In the midst of this, Japan thrives on capitalism yet spends one of the smallest percentages of its gross domestic product on healthcare while the United States spends one of the highest percentages. A brief account of physicians and the origin of health insurance practice will shed light on such situations as they exist in healthcare today.

Health insurance in Japan is equitable, and is composed of employment-based health insurance and residence-based health insurance, of which there are several categories. The insured patient in Japan is free to choose their doctor and treatment that they receive.[13] Japan regulates government spending on health care through a standard fee-for-service system consistent in all municipalities that reflects health care coverage in the nineteenth century; national health insurance is rooted in preserving the health of the working class in Japan's modern past, and residence-based insurance took its initial forms in physician remuneration in the 1800s.[14] Later, the important enactment of the Health Insurance Law of 1922 provided health benefits[15] to workers who were a crucial population when building up Japan as a nation in the Meiji era. Its enactment is important

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[13] Naoki Ikegami, "Japanese Health Care: Low Cost Through Regulated Fees," *Health Affairs* 10, no. 3 (1991) : 88.

[14] John Creighton Campbell, Naoki Ikegami, and Yusuke Tsugawa, "The Political-Historical Context of Japanese Health Care," in *Universal Health Coverage for Inclusive and Sustainable Development, Lessons From Japan 2015,* ed. Naoki Ikegami (Washington DC : International Bank for Reconstruction and Development / The World Bank, 2014), 17. A sum of pre-payments was collected from village residents for doctor services during dire times, which had kept physicians from remaining in unfortunate locations.

[15] Campbell, "The Political-Historical Context of Japanese Health Care," 18.

because this is the foundation for the health insurance system in Japan today.[16] During

the Meiji Restoration Japan promoted efforts for modernization as Japanese ones[17]

through the use of *bunmei kaika*, civilization and enlightenment.[18] It is interesting to view

a system of health coverage as something that also "demarcated a crisis of Japanese

modernity" with other national efforts towards a unified national state in the early

1900s.[19] Having health insurance for workers implied that modernization could be

achieved ideally without falling victim to infectious disease, and possibly limiting other

new modern deaths, although this did not happen to be the case later on.[20] Gradually,

Japan had integrated biomedicine into formal study, which arguably complemented the

existing practice of *kanpo* medicine that had already existed in Japan.[21] This of course

ended when Meiji government officials phased out the status of *kanpo* doctors for the

professional status of biomedical physicians who were passing their formal examinations

and becoming these licensed professionals by the 1880s.

Health insurance and physicians fulfilled a different role in America in the early

1900s because politically, the US was not as centralized[22] as European countries, or

Japan for that matter. The launch into market healthcare for the United States was largely

influenced by the nature of the economy at the time, but in its primitive form healthcare

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[16] John K. Iglehart, "Japan's Medical Care System," in *Health Care Systems and Their Patients 1992,* ed. Marilynn M. Rosenthal and Marcel Frenkel (Boulder : Westview Press, 1992), 149.

[17] Marilyn Ivy, "Ghastly Insufficiencies: Tono Monogatari and the Origins of Nativist Ethnology" in *Discourses of the Vanishing,* Marilyn Ivy (Chicago : University of Chicago Press, 1995), 73.

[18] 文明開化 (*bunmei kaika*): Civilization and Enlightenment, used in the Meiji period to promote modern thought.

[19] Ivy, "Origins of Nativist Ethnology," 68.

[20] Public health initiatives and activities were severely marginalized as japan approached the Second World War. This content will be discussed more in chapter two.

[21] 漢方 (*kanpou*): Doctors in Japan who study Chinese derived medicine.

[22] Leiyu Shi, "Historical Overview of US Health Care Delivery" in *Essentials of the US Healthcare System 2005*, Leiyu Shi and Douglas A. Singh (Boston : Jones and Bartlett Publishers, 2005), 58.

was restricted to a very domestic sphere. While licensure of physicians did emerge state by state in the early 1800s, it was almost completely abolished since patient autonomy and patient choice were valuable aspects of care. Doctors were paid fees for their services, but these doctors were not necessarily professionals, and the medical economy remained a domestic[23] one in the nineteenth century. Transactions and choice stayed between the patient and the physician. While Japan remunerated physicians to keep them in rural areas in the late 1800s, when urbanization sent many to larger metropolitan areas, "unrestricted entry into practice" in the United States meant that "doctors were apparently well distributed through rural areas."[24] By not having many professionals in practice and a less restrictive system of licensure, political economy was too decentralized and education too burdening, therefore demand in small towns and other rural communities sufficed and national health insurance did not have a sturdy platform on which to develop. Hence, one proposed reason for why the US has yet to acquire a system of national health insurance, much less a universal healthcare system.

With this bit of information concerning early physician status among political, economic motives, hopefully it is easier to see a correlation between the standing of health insurance today and the roles of physicians within their respective healthcare systems as professionals. Of course, much more contributes to the status of the healthcare system in its present state in America and in Japan, but this paper will not specifically go into further discussion about hospitals, policy or public health. Instead, history shows where inconsistencies in professionalism have contributed to complexity in healthcare.

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[23] This implies that most often transactions occurred privately between the physician and the patient.
[24] Paul Starr. *The Social Transformation of American Medicine* (New York : Basic Books, Inc., Publishers, 1982), 64.

Government Spending on the Patient

America, without national health insurance but instead a large sector of private insurance, spends a considerable percentage of GDP on healthcare. Public spending is reserved for patients without proper funds and elderly patients, while those who can afford to pay for the insurance and receive employer benefits use private spending. According to an approach used by Christian Aspalter,[25] the Welfare systems and per capita spending of the United States is nothing less than social, and approximately 48% more social than Japan, a country that is known for practicing and promoting a system of Universal Health Care (UHC) and National Health Insurance (World Bank). Japan's regulated fee schedule is successful at containing costs. For instance, Aspalter states that "the United States would be among the top three world health care systems in terms of 'socialism,'" which is something an American might not have ever considered, in terms of America's governmental spending.[26] This is because "when it comes to absolute public health care spending the USA is also a large public health spender, the third largest in the world."[27] Specifically, this is looking at "the absolute *public spending per capita for health care.*"[28] The tables below present extracted data from Tables 10.1 and 10.3 in Aspalter and Uchida's work, and current data from World Bank and WHO that compare Japan and the United States.

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[25] Christian Aspalter, "European and Asian health care systems in comparative perspective" in *Health Care Systems in Europe and Asia 2012,* ed. Christian Aspalter, Yasuo Uchida, and Robin Gauld (New York : Routledge, 2012). Aspalter uses data to show how the health care system in the US is approximately 35 percent more socialist than the health care system of the United Kingdom, which tends to be the prime example of socialized medicine from an American perspective. Another point worth noting is that the Welfare system in the US is also a very socialized system of health care.
[26] Aspalter, "European and Asian health care systems," 167.
[27] Aspalter, "European and Asian health care systems," 182.
[28] Aspalter, "European and Asian health care systems," 167.

Table 1. Comparing government spending on healthcare in Japan and the US

	Health expenditure, total, % of GDP (World Bank, 2013)	Per capita spending on healthcare, USD (World Bank, 2013)	General government expenditure on health as a percentage of total expenditure on health (WHO, 2013)	Per capita spent on health by government based on 2013 data, USD
Japan	10.3	3,966	82.1	3,256
United States	19.7	9,146	52.9	4,838*

*The United States government spends approximately 48.5% more per capita on healthcare than Japan. In terms of this data, and using the framework of Aspalter's argument specifically, it can be argued that "the health care system in the United States... is actually about [48] percent more 'socialist' than that of [Japan]" (167).

Government spending on healthcare in Japan and the US continues to increase as a result of aging populations and subsequent complexities in health insurance policy, but also because of the technology, changing market forces, problems in health care delivery, and globalization that are simultaneously making it difficult for professionals to meet their responsibilities.[29]

Why Medical Education is Changing

Now that the reader is familiar with some context of healthcare issues in the US and Japan, these observations can be used in an analogy. Just as the complex status of healthcare today is influenced by its professional origins, the history of medicine as a licensed profession has long influenced both patients and professionals in healthcare. Similarly, the same medical training for nearly one hundred and fifty years has perpetuated patient care compromised by inconsistencies in professionalism. Licensure made practicing physicians into professionals once they completed necessary medical education, removing them from domestic relationships and placing them into political

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[29] Harold C. Sox, "A Physician Charter," 244.

and market economy sectors in Japan and the United States, respectively. Training as a physician professionally meant gaining access to patients in university hospitals for training purposes, a method now revolutionized by objective structured clinical encounters.[30] For this reason in particular, focusing on professionalism as it is taught in medical education is crucial. The physicians that the profession has produced since the end of the nineteenth century have contributed greatly to the field of healthcare, and the consequences of their formulized training then is bringing about a change in medical education now.

What has impacted patients the most? Patient autonomy is still valued in the healthcare system, but obvious issues such as insurance and government spending put restrictions on patient choice. For both America and Japan, physicians were licensed professionals by approximately the year 1890. As the next chapter will outline, the US was influenced by Europe as much as Japan had been, but at the same time, the shift to biomedicine, Western medicine, took different courses from different origins in these nations, and yet, patient situations are becoming evermore complicated such that the training of physicians is changing.

Readjustments to medical education have already been executed in select universities in the United States. As for Japan, patient care and professional awareness is becoming a frontier focus in medical training.[31] While biomedicine is a dynamic social

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[30] Objective structured clinical encounter (OSCE): training in medical education involving standardized patients to create a clinical environment for medical students where both students and patients suspend disbelief.
[31] The use of standardized patients in Japan is not employed in the same ways as it is in the United States. Training medical students in the US experience more simulated encounters than Japanese students, but this specifically has been identified as an area for change for the sake of future physicians in Japanese health literature.

science, medical education has remained stagnant since the adoption of the profession through licensure in the late nineteenth century, assuring a standard that would produce the most professional of physicians. Licensure is a main component of many professions, not only healthcare.

As this paper will continue to suggest, medical education has recently become an avenue for change, mostly by training professionals not to think quantitatively, but qualitatively about the patient care they are delivering. Therefore, training students with more qualitative social science skills can foster stronger professionals in the field. For the US, this has taken a patient focused turn in education and for Japan it has taken an international focus, with particular interest in professionalism and what it means in a Japanese context. One could predict that the combination of the two will help to communicate changes in the US to Japan, frontier programs in Japan to the US, and Japan's synthesis of international medicine into their own system. This sudden qualitative shift could critically analyze healthcare's own professional methods as a negative impact on the systems overall since modernity. At the founding of the professions during industrial ages and rapid decades for societal change in the late nineteenth century, perhaps the negative consequence of professionalism was unavoidable at the time. Today, it is possible to survey consequences in clinical encounters that have been perpetuated by professional medical training, and now is the time to recognize them.

Medical physicians are considered professionals in both Japan and the United States today, but again, this identification is the product of two different systems, and two different births of biomedicine. This thesis will argue, but not discredit the efficacy of, professionalism as a concept that has influenced the way patients are perceived. Most

importantly, this thesis will investigate how professionalism is taught currently since the medical training of physicians is changing for the first time in one hundred and fifty years, which reveals how now would be the time to correctly and concretely outline medical professionalism for the sake of future physicians.

Moving forward, the second chapter of this thesis will attempt to identify the critical events that made medical physicians professionals, in two separate and unique biomedical systems that continue to express the same symptoms of patient care, aging population, financial and policy driven burdens. It will begin the discussion on how a medical profession meant to provide care was compromised in its relationship with its patient, all by licensing physicians and creating professionals facing variable and complex issues in healthcare; it will look back on the past to attempt to identify when the consequences of the professional problem became the first symptoms of the illness.

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村上義孝. "平均寿命だけがどんどん延びていったら……," *朝日新聞* March 4, 2016 http://www.asahi.com/articles/SDI201603030425.html

Chapter I. Past Medical History

Although there is not an overwhelming amount of evidence to support this, it is possible that the development of the profession of medical physicians apart from other occupations created stress on the doctor-patient relationship, having an affect on how the relationship is perceived today. With healthcare issues becoming more and more complex, professionals are limited in their time that they have with patients, not to mention various stressors that affect the behavior of professionals and communication between physicians and patients. If professionalism is considered the unforeseen, underlying context of complexity in healthcare, then reviewing the history of physicians as professionals is a necessary component to understanding how misconceptions in professionalism have the potential to be sustained in training and practice today.

The Physician Charter on medical professionalism was an essential step towards more structured study, acknowledgement, and discussion of professionalism by professionals. It points out that professionalism and professional medical practice may not be consistent in other cultures as it is in Western thought, going on to specify that the charter is intended to be applicable from a global perspective.[32] The charter questions directly its own representation of traditions of medicine in other cultures.[33] In the context of medicine that is practiced in Japan and the US, however, this question omits the details of the origins of biomedicine in nations across the globe by isolating the West and creating a single "other" category. Both Japan and the US begin to adopt biomedical practices early on from European influence, but both countries adopted biomedicine in a way that was tailored to fit the current situations at the time. For instance, before

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[32] Sox, "Charter," 244
[33] Sox, "Charter," 243. "Does this document represent the traditions of medicine in cultures other than those in the West, where the authors of the charter have practiced medicine?"

licensure, many forms of medical practice were considered primitive because licensure

did not standardize practice. America experienced a sense of fragmentation as a result of

the Civil War (1861-1865), and Japan by the Sengoku Period (1467-1603). Though by

the end of the nineteenth century, physicians in both countries experienced a change in

status from domestic workers to trained professionals, along with which came the nature

of responsibilities regarding professionalism that the charter reiterates. For this reason in

particular, understanding the history of medical practice as a professional one is key to

further investigation of professionalism in practice and in medical education in Japan and

the US.

This chapter will separately discuss licensure, European influence, integration of

biomedical practice, histories of professional licensure and training for Japan and the

United States. In addition, these histories will be assessed for compromise in patient care

in the early twentieth century, where a sudden influx of training medical physicians

needing access to patients tested the altruism of the profession.

Japan

By 1868, biomedicine was already on the political agenda for becoming a part of

medical practices inherent to Japan at the time. The institute for the medical profession,

the Institute of Western Medicine, was renamed and this time, the word "Western" was

omitted from the title.[34] Shortly thereafter, the Bureau for the Examination of Medicine

was established in the city of Tokyo as a part of the Department of Education a year

before Tokyo University's medical school was established in 1875.[35] By 1903, all of the

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[34] Willis Norton Whitney, "Notes on the History of Medical Progress in Japan." *Transactions of the Asiatic Society of Japan* (Yokohama) 12, (1885) : 344.
[35] Whitney, "Notes on Medical Progress," 394.

physicians teaching at this medical school were Japanese,[36] even though less than a

quarter of physicians in Japan at this time practiced newly indoctrinated practices of

Western biomedicine.[37] Although foreign physicians still had a small role in medicine at

this time, Japan began to set a precedent for the nation's medical profession through

Tokyo University, and rather than requesting the assistance of foreign doctrine, charged

its own students to study in Europe.

Adopting European Doctrine in Japan

Before the European introduction of Western medicine, healing existed in Japan

in the form of *kanpo*.[38] As a matter of fact, some scholars specifically mention how

"Europeans had little of value to teach regarding the art of healing" in Japan, [39] given that

healing was already a practice before Western medicine arrived there. What the

Europeans did offer, arguably, is a set of new methods with which to approach medical

practice to a Japan preparing for a new modern era by the time of the Meiji Restoration in

1868. According to Genpaku Sugita, the Dutch methods for healing were "far superior to

the Chinese or Japanese methods theretofore employed."[40] In the early seventeenth

century, when the Japanese began discourse with the Dutch by 1608, resources for

modern medicine were introduced in the forms of anatomy books, lectures, and visits to

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[36] Yoshio Izumi and Kazuo Isozumi, "Modern Japanese medical history and the European influence," *Keio Journal of Medicine,* 50, no. 2 (2001) : 97.

[37] Carl Mosk, *Making Health Work* (Berkley : University of California Press, 1996), 89.

[38] *Kanpo* is a Japanese medical approach to healing based on Chinese principles practiced by self-employed physicians. This is why, from one perspective, Japan should not be identified with medical pluralism, a term used in medical anthropology to describe a society that has more than one healing system at the disposal of those who are ill or in need of healing.

[39] Harald Fodstad, Marwan I. Hariz, Hidehiro Hirabayashi, and Chihiro Ohye, "Barbarian Medicine in Feudal Japan," *Neurosurgery* 51, no. 4 (2002) : 1019.

[40] Whitney, "Notes on Medical Progress," 312.

the emperor.[41] This influence begins the gradual internalization of biomedical practice

into Japanese healing methods. The following comment by Hanaoka Seishu offers some

clarity concerning the roots of this new Japanese approach to healing, and the association

between European medicine and *kanpo* as an embodiment of the same longstanding goal:

treating patients.

> There is no distinction in principle between ancient and modern medical treatment, while in the treatment of internal and external disease the principle is one: if, therefore, we permit ourselves to be biased toward the teachings of the ancients, we may fail to understand those of today; while if we do not consider the internal condition of the body, how can we treat understandingly those diseases which manifest themselves externally? The Dutch physicians are most minute in theory, but rough in their mode of treatment: Chinese science is indeed minute, or accurate, in practice; but is restrained by the theories of the past. Therefore, as to treatment, I look to the living body alone for indications, seeking for the mode, afterwards, from philosophers; and am consequently not restricted to rules giving remedies, but act as necessity demands. When medicines are ineffectual, as well as acupuncture and the cautery (moxa), the abdomen and back may be opened, the stomach and intestines washed, and whatever is likely to save the patient, may be done.[42]

Japanese physicians started to internalize newly introduced Western medicine, using an

approach that adopted both Dutch and traditional Chinese practices. Seishu's comment on

the principle of medical treatment in Japan not only contextualizes how modern medicine

from Europeans was received, but how well this modern medicine was received.

Succinctly, the Dutch practice was embraced because upon revision and speculation, their

methods for healing from a Japanese perspective were in need of modification, but

"superior" to what was currently in practice.

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[41] Access to medical texts early on was limited to the extent that Japanese physicians could only take notes from lectures delivered by Dutch medical physicians. Western anatomical texts were not published in Japan until later.

[42] Whitney, "Notes on Medical Progress," 313. Quote by Hanaoka Seishu.

The embrace of the modern medicine that Seishu refers to, however, did not come to Japan without a price. Religious motives and charitable operations established foreign hospitals in Japan, as well as the foreign relations that Japan chose to avoid during the Tokugawa Era. One speculation for this is that "although a few hospitals were established by political leaders or monks, Japan lacked a developed tradition of religious and secular charities that supplied medical care or operated hospitals."[43] Japan did not have what is thought of today as "hospitals, or even public or religious institutions that could serve as the nuclei for hospitals...before Westernization."[44] Moreover, Japan was not a centralized political state when Western medicine first made its impression in the seventeenth century. The Tokugawa Shogunate was governed by cultural ideals largely in isolation from global affairs or influence. Politically and professionally for the Meiji era, however, hospitals became closely tied to medical institutions because the need for medical personnel was prompt once licensure standards were set by the government. Nevertheless, by 1910, the amount of physicians practicing had severely decreased.[45] Because central authorities developed policy in order to raise the standards of medical and public health personnel into the early twentieth century,[46] the training and qualifications of physicians for these systems followed suit, thus cutting *kanpo* practicing physicians out of the modern equation of medicine.

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[43] Marc A. Rodwin, "The Evolution of Japanese Medicine" in *Conflicts of Interest and the Future of Medicine: The United States, France, and Japan 2011.* Marc A. Rodwin (Oxford : OUP, 2011), 163.
[44] Naoki Ikegami, "Factors Determining the Allocation of Physicians in Japan," in *Universal Health Coverage for Inclusive and Sustainable Development, Lessons From Japan 2014,* ed. Naoki Ikegami (Washington DC : International Bank for Reconstruction and Development / The World Bank, 2014), 121. In fact, it was not until religion was removed from the Western hospitals that the institution had actually become successful. A convoluted relationship that developed between Japan and its religious, foreign diplomats during the isolationist period of the Tokugawa Shogunate, which ended at the Meiji Restoration in 1868, is one of the reasons why these hospitals were not successful.
[45] Mosk, *Making Health Work,* 93. Table shows a drop in physicians
[46] Mosk, *Making Health Work,* 90.

Undoubtedly, "Dutch ships brought a variety of Western knowledge," but the

political atmosphere at the time meant "that knowledge had no profound effect on the

secluded Japanese society during the major part of the seventeenth century."[47] That is,

having "no profound effect" from a Western point of view. By 1774, Sugita had

completed a translation of the first Dutch medical text into Japanese, the celebrated

Kaitai Shinsho, "New Text on Anatomy."

The above figures are pages from an original copy of Genpaku Sugita's Kaitai Shinsho, *courtesy of the Keio University Library's Digital Gallery of Rare Books & Special Collections. On the left, a pair of bodies on page 59 of the volume is also the backside of page 58, a recognizable, classical European figure shown to the right. The dissected bodies are merely simple outlines in the middle of profound Japanese text. These dissected bodies are an exquisite representation for the metaphorical dissection of the Dutch doctrine into a precedent for an adopted method of healing by 1868.*

Kaitai Shinsho is not the first product of translating Dutch medical text, but it is

the first completed, published volume in Japanese. Although Japan was considered

isolated during the eighteenth century, European influence before this period still led to

the adoption of methods afterwards that scholars translated and studied, and the product

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[47] Fodstad, "Barbarian Medicine," 1020.

of these efforts became concrete adoptions of the doctrine, such as *Kaitai Shinsho.*

Over a century after the publication of *Kaitai Shinsho*, Whitney incorrectly remarks in 1884 that, "indeed Western, medicine can hardly be said to have been practiced to any extent in Japan until within the past few decades of the present century,"[48] that is, around the time of the Meiji Restoration in the late nineteenth century. According to this research, on the contrary, it is not Whitney's *Western* medicine that Japan did not practice until the late nineteenth century, but instead an integrated, Japanese system of practice that did not come into its own, professionally, until 1868.

Licensure of Professionals in Japan

For the duration of the Tokugawa Shogunate (1603-1867), "medical practice was unrestricted," without a professional form of "licensing"[49] but Japan already "had many well-established private practitioners of traditional medicine" by the time that Sugita's *Kaitai Shinsho* was published.[50] Physicians who practiced *kanpo* did so by self-employment, and there were plenty of private practices. These physicians, however, lacking license, were neither autonomous parties, nor ever characterized by elevated status, and therefore could not differentiate their practice from other literary scholars with professional practice. That is to say, individuals who did not practice medicine began to contribute to medical methods at a time when Japanese physicians were trying to translate and understand the methods of modern medicine, as the following observation from 1885 highlights.

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[48] Whitney, "Notes on Medical Progress."
[49] Rodwin, "Evolution of Japanese Medicine," 162.
[50] Ikegami, "Allocation," 120.

There were many literary men who, intruding upon the domain of medicine, wrote commentaries on medical works with popular explanations; and who, often following too closely the letter, and mistaking the real meaning of text, bred confusion among those who relied upon these erroneous explanations.[51]

New, modern methods in medicine meant new medical education, and would require an unprecedented set of standards for this physician training.

The government introduced licensure for all physicians, and this arguably is the event in Japan's medical history that secured a sense of professionalism in the physician role. Licensing increased the level of qualification standards; medical education became required and quite accessible, setting physicians of modern medicine apart from physicians of traditional medicine.

… at a time when regional beliefs and practices were being threatened by the comprehensive state ideology of 'civilization and enlightenment' (bunmei kaika); this ideology was backed by fiercely ambitious policies and programs for inculcating modern habits and ideas into the populace. The widespread importation of western knowledge during the Meiji period led to a questioning and reassessment of native forms.[52]

As was already discussed, modern medicine was among the import of knowledge from the West. Meiji period policy affected *kanpo* doctors specifically because developing licensure qualified the physicians of Western medicine as the true medical professionals for the new modern era, thereby strategically distinguishing the new physicians from what Ivy comments on as "native forms."[53]

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[51] Whitney, "Notes on the Progress," 316.
[52] Ivy, "Origins of Nativist Ethnology," 70.
[53] This holds the capacity for a dual meaning. Reassessment of native forms can refer to the compromise of *kanpo* practice that, although with Chinese influence, is intrinsic to Japan. Secondly, it suggests that Japan cannot be defined as medically plural when considering *kanpo* and biomedicine alone. The way in which biomedicine was gradually adopted into medical practice in Japan complemented the medical study that already existed there for centuries.

While medical education became accessible, a deficit in available practicing physicians became a harsh reality. Tokyo University's Medical School employed a number of foreign physicians who were later replaced by competent Japanese graduates with their own personal experience of study gained in Europe, especially Germany. Government officials had accepted German practices of biomedicine in university education in 1869. Although medical students were increasing in numbers and modern medicine became a standard of practice that the medical schools put forth, still "there were five times as many traditional practitioners" than physicians trained in modern medical practice. Medical schools and hospitals, which grew in a parallel fashion since patients were a key aspect of modern medical education,[54] were created by the state. In 1875 and 1883, it was necessary to have a biomedical degree in order to practice.[55]

Formal licensure in 1882 included already practicing *kanpo* physicians. In 1883, the government issued licenses once more to physicians to authorize their practice, but the new system of licensure required an examination focused exclusively on biomedical practice, not on *kanpo.* Some say that the Tokugawa legacy remained even into the beginning of the Meiji Restoration, which the revolution of medical practice clearly illustrates, since government officials systematically had to give preference to Western medicine over *kanpo*. But once modern medicine became an internalized practice in Japan as biomedicine, state-issued biomedical licensure became a requirement for qualified physicians, giving the profession its autonomy over traditional methods of healing. The Meiji government made a clear assertion with these actions to expand biomedical education to prepare for the new, the modern Japan of the twentieth century.

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[54] Ikegami, "Allocation," 121.
[55] Rodwin, "Evolution of Japanese Medicine," 165.

Early Medical Training in Japan

Proliferation of both medical universities and government-run vocational medical schools created a sufficient amount of biomedical graduates. While prerequisite standards across schools were not equivalent, both sets of medical students had to pass the same licensing examination that began in 1883. Medical education became accessible to those who were competent at the university level standards, as well as accessible to those entering at the lower level of the dual structured medical education system. This meant that "world-class standards in physician training" became the overall standard, and many medical students were thereby professionally trained.[56]

Adopting biomedicine into the twentieth century approach to medical practice came with a price, but introducing professionalism into the physician role came with a price as well. By making physicians train and test for licensure, medical practice was set apart from domestic practices as a profession.[57] The Meiji Restoration turned students of modern medicine into new professionals, in a new, modern Japan. The Restoration also opened "elite, public medical schools and affiliate hospitals" for clinical education in biomedicine, and "a few not-for- profit Western medical schools and hospitals, notably Keio University."[58] Therefore, not only was Tokyo University's medical school setting a precedent in education by 1875, but Keio University's medical school began to set a standard for medical education since its opening in 1920. Keio University, or *Keio Gijuku*, was relatively influential in biomedicine in Japan before the establishment of a medical

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[56] Ikegami, "Allocation," 120.

[57] Medical care was often delivered at home or by local family doctors in private settings in both Japan and the US. In most cases, these doctors did not have adequate training experience, despite their claims.

[58] Rodwin, "Evolution of Japanese Medicine," 165.

school; Fukuzawa Yukichi had established a disease research institute in prior years. Medical schools took after Keio and Tokyo Universities,[59] and various municipalities developed similar medical schools with hospitals, where patient access would be guaranteed. But a seemingly minor side effect presented; in the midst of a rapid rate of modernization and new medical education, efforts for a better version of Japanese medicine through training were counterproductive to raised quality standards in health, compromising individual patient health. This is when symptoms of stress on the professional system began to present. In fact, it is symptomatic of stress on medical education today.

The United States

Around 1870, hospitals were redefined from being charitable in nature to being prestigiously associated with universities. Harvard University, like Tokyo University, set a precedent in medical education for its nation. Physicians were finally encountering the standards intended for professional practice and licensure would soon follow. By this time the United States was already aware of needed reform of the medical system following the Civil War, but an arguable air of democratic politics clouded the boundaries of patient autonomy within medicine. The American Medical Association attempted but did not achieve licensure in states because "nineteenth century America did not readily provide the political and institutional means to guard entry to professional status."[60] Hence, even when American physicians sought professional recognition at the

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[59] Especially for Keio, this is still the case today. A later chapter will discuss Keio's national influence in medicine, and the ways in which the US can benefit from them.
[60] Starr, "Social Transformation," 37.

end of the colonial era[61] a sense of patient autonomy and a decentralized market left

physicians without licensure until 1898.[62] From this point, however, the medical system

still did not necessarily improve. Perhaps, for the patient, it still has not improved.

English Influence and Democratic Influence on Medicine in the US

America's political situation of colonial democracy severely shaped the form of

any emerging medical body. Guilds parented medical practices, but not within the status

of a working medical society. Although initial medical influences and practices were

grafted from England, the US began to engender all combinations and practices of

healing that had no restriction on their practice in the eighteenth century. Unlike Japan,

the United States did not reap the benefits of elite physicians migrating into the country.[63]

Guilds did not have power over the people, and even less so over state

governments. Unregulated practice at this degree made medical practice so common that

almost anyone could claim to know a bit of medicine. In some ways, the primary body of

medical practice in the United States in the eighteenth century was quackery; nothing

about the origins of medical practice in the US was professional.[64] Some accounts of the

medical situation in the 1800s emphasized the prominence of quackery among trade-like

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[61] Starr, "Social Transformation," 30.

[62] This is at least a decade after Japan already licensed its physicians to practice in Western medicine; physicians in Japan practiced Western medicine professionally before physicians in the US.

[63] Starr, "Social Transformation," 39. Starr comments on how English physicians had no reason to visit the US for either medical training or experience, whereas Japan profited from German physicians, for instance.

[64] Quackery was especially a conflict with the dispensing of medicine. Many people claimed to have efficacious drugs for common ailments, none of which were exceptionally effective and only brought the quack a large sum of money. Without professional societies like those found in England and other parts of Europe, there was no way of regulating this phenomenon of quack medicine, until licensure of physicians and the creation of a professional class of medicine was attained.

practice. In Livesey's Moral Reformer of September, 1838, the nation is blatantly

reprimanded.

> Looking at the quack advertisements which fill up the first page of almost every newspaper, I had thought *we* had no small proportion of quackery in *this* country. However if we can give credit to the following notice, in this as in many other matters, we are still behind, America. The reason I conceive, why these quacks are not oftener exposed is this; those who will not purchase these "invaluable" and "unrivalled" medicines, think them beneath their notice; those who *do* purchase, finding that they have been *gulled*, in order to preserve their own credit in society for having a little common sense, and to prevent being laughed at, remain perfectly *mute* upon the subject.[65]

Here the reader should notice something negative about democracy. Not only

does this passage reveal the extent to which medicine existed as a common trade, it

delivers a less acknowledged, negative perspective of democratic politics in eighteenth

century America. That is to say, when uneducated patient autonomy restricted medical

practice within the boundaries of domestic affairs, untrained practice only proliferated.

The politics of medical practice were as such: metaphorically, by electing for patient

autonomy over licensed professionals, patients inadvertently had already elected for

decades of stagnant medical advancement and ineffective medical treatment. Medicine

was inauthentic, the converse of altruistic, without any way of attaining standards for

health. Democracy at these premature stages of medicine created quite the unequal stage

for a nation of equal opportunity. Keeping medical transactions between the patient and

the physician without a professional body resulted in resentment, no reconciling standard

for health care delivery, and quackery extending well into the nineteenth century. The

behavior of quacks as superior to the rest of the population was foreshadowing of the

status that professional physicians would hold in the decades to follow.

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[65] Joseph Livesey, "Extent of Quackery in America," *Livesey's Moral Reformer* 18, (Sep 1838) : 156.

For those who were aware of the prevalence of quackery in America, it was safely assumed with little doubt that "quackery flourish[ed] in America to an extent unknown in other lands."[66] The public played doctor on themselves, thereby targeting common ailments[67] that gained attention, sparked revenue, and continued the malpractice.

Licensure of Professionals in the US

In order to separate medical practice apart from other domestic occupations, licensure was needed to make a significant change to the medical system. Stricter degree requirements and prerequisite education was proposed as early as 1825,[68] but such earlier efforts were stomped out by the reality of a domestic economy and democratic politics. Hence, the dissolution of reform attempts in the 1830s and 1840s.[69] No real reforms had the appropriate habitat in which to thrive since medical institutions were only open because making professionals meant making money.

> … in the care of the sick, as in other activities, private choice should prevail- hence their support for the abolition of all medical licensing. They thought people should be able to contract treatment with whomever they wished; the market, in other words, could best regulate itself…. In different ways, professionalism, charity, and government intervention were efforts to modify the action of the market, without abolishing it entirely.[70]

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[66] John C. Dent, "Quacks and Quackery in America," *Once a Week* 10, no. 246 (September 14, 1872) 235-38.

[67] In this article from Once a Week, John Dent also criticizes the young America and her citizens indirectly for her freedom and democracy. "A great variety of causes contribute to make the people of America particularly susceptible to such disorders… the restless, feverish habits of life; the continual, never-ceasing exertions to acquire the almighty dollar; the preference for pastry and unwholesome confections as articles of food; and the stimulating atmosphere which is almost universally prevalent on the other side of the Atlantic, may be mentioned as the principal of these causes… these alone are amply sufficient to account for the actual state of affairs" (235).

[68] Martin Kaufman, *American Medical Education, The Formative Years, 1765-1910* (Westport, CT : Greenwood Press, 1976), 78.

[69] Starr, "Social Transformation," 62.

[70] Starr, "Social Transformation," 61.

The creation of the American Medical Association is arguably the moment when licensure was truly sought out in the US, but a nationally adopted method of licensing physicians would not come to fruition until 1898. When medical societies, schools and hospitals came together to found the AMA in 1847, a specific intention was to restrict entry into medical practice. Unlike Japan, the methods of medical practice in the US after the Civil War, as mentioned above, truly were primitive. Lax education standards through apprenticeships propagated unprofessional training and the plans for marriage between the US medical system and the market economy price-tagged ill patients while also shaping them into objectified educational mediums. Professionals in medicine had abandoned the responsibility of observing patient autonomy once licensure was able to override democracy, and consequentially the altruism of the practice. This is symbolically represented by the change of hospital roles during this time. Hospitals went from charitable institutions to educational ones, and the professionalism of the medical practice became a status symbol of capitalizing care.

Licensing professionals and the shift of medicine towards the market economy meant that physicians began leaving the more rural areas of the country for cities.[71] And, much like Japan, the increase in standards for physicians reaped less available resources in the beginning of the twentieth century. By restricting entry to practice, only select physicians made it to the professional level.

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[71] The divide between available physicians and rural communities is still a real conflict today within medicine. Some university hospitals that experience severe cluster, such as the University of Washington in Seattle, have made it part of their goal to reach out and send medical students to rural areas for clerkships, thereby decentralizing care through effective medical education.

With physicians gaining influence in hospital activity without being employed there, eventually autonomy shifted from the patient level to the state level, and states made licensure legislative practice by 1896.[72] By this time, Japan was already requiring the licensure of physicians for over a decade; physicians in Japan were licensed professionals of Western medicine thirteen years before physicians in the US received these privileges from their state governments.

Early Reforms for Medical Training in the US

In 1914 the AMA published its listing of internships[73] which served to enhance the medical training of graduates, a precursor to residency programs that are now required in US medical education. Part of this was necessary to counteract a sour trend of producing medical physicians through lax enforcement of training standards. A history of the blind leading the blind through apprenticeships meant that at one point, almost anyone could enter medical school with the correct bill for tuition. Because the medical profession in the US became so closely tied to the market economy and the earning of a livelihood, investments in medical education by professors and other physicians was an economic one. Explicitly stated, the primary concern of physicians for ill patients was fostered by the need to earn a livelihood.[74] Regardless then of the initiated reform placed on medical education, the training of future physicians from the 1870s onward, the situation in professional American medicine worsened.

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[72] Kaufman, "American Medical Education," 143. In reality, only 23 states total out of 45 states were requiring physicians to be licensed by the new standard. The significance of stronger government
[73] Starr, "Social Transformation," 124.
[74]Marc A. Rodwin, "The Rise of a Protected Medical Market, The United States before 1950" in *Conflicts of Interest and the Future of Medicine: The United States, France, and Japan 2011*. Marc A. Rodwin (Oxford : OUP, 2011), 80.

Here, the reader can see how not maintaining professional responsibility had a direct impact on the care that patients received at the end of the medical system that altruistically matters the most. The following section investigates other effects of producing professional physicians in Japan and the US at the beginning of the twentieth century.

How the Influx of Professionals Creates Consequence:

Professionalism and Impatient Facilities

Once the standards of medical training and physician practice increased, medical resources decreased. For instance, as standards increased, hospitals decreased via consolidation and the number of physicians practicing in Western medicine professionally was low for a time in both the US and Japan. When prefectural funding of medical institutions ended for Japan in the 1880s, only a few remained funded by the government while the rest went private. These schools became national medical universities later on.[75] Therefore, before these two nations experienced an influx of professionals, there was a deficit. As was already discussed, in the case of Japan this was largely influenced by politics, and in the United States by the shifting economy from a domestic stage to a market monopoly. Lacking professional physicians, both nations rebounded by educating new students in vast numbers, where some were more equipped than others.

Education after the medical degree hence became more valuable but simultaneously scarce for the United States. Training and practice opportunities were few

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[75] Shizu Sakai, "History of Medical Care at Inpatient Facilities in Japan," *Japan Medical Association Journal* 54, no. 6 (2011) 353.

in number, and discriminated populations[76] received even lower standards of medical

care despite the education reform. Educational reform in Japan also narrowed the influx

of medical students that institutions were putting forth, but discrimination occurred

among professionals rather than among populations.

> One of the consequences of this policy of standardizing around Western medical principles was a temporary reduction in doctors per person. The kanpo doctors aged and eventually either died in active service or retired. Due to inevitable delays in the establishment and staffing of educational and medical institutions designed to train young personnel in Western methods, replacements to the ranks of the medical profession were outpaced by the older generations of kanpo doctors… even in the area of medical personnel the legacy of the Tokugawa period lingered far into the Meiji period.[77]

Therefore, despite the fact that Japan was able to manage the types of physicians that

would tend to the working populations and citizens of a modern Japan, quality did not

necessarily improve, nor health enhanced, by attaining higher educational standards,

contrary to what Denison and Chung argue.[78] Economically it might have been the case

that the health of workers and conditions improved for a time, but in reality, civil public

health was sacrificed as a means of resource containment.

> …increased industrialization and urbanization on the four main islands of Japan, plus the dominance of military aims over all social welfare activities, had a pronounced influence on public health and welfare administration…. Such as a rapid turnout of medical students… it also resulted in the cessation of many public health activities of benefit to the civilian population.[79]

> By drawing more doctors out of rural areas, as with the United States, and rapidly

producing the medical students of Western medicine that the Meiji government had

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[76] Starr, "Social Transformation," 124-5.
[77] Mosk, "Making Health Work," 90.
[78] Carl Mosk, "Japanese Industrialization and Economic Growth, Appendix: Sources of Growth Accounting and Quantitative Aspects of Japan's Modern Economic" *Economic History Association*, March 20, 2016. https://eh.net/encyclopedia/japanese-industrialization-and-economic-growth/.
[79] Iglehart, "Japan's Medical Care System," 150.

orchestrated from the late nineteenth century licensure standards, individual patient

health was undoubtedly compromised. Training medical physicians was more likened to

mass-producing the next generations of future physicians, where "so much emphasis was

put on the education of young doctors that the patients' welfare was neglected and they

were sometimes referred to as doctors' laboratory specimens."[80] This should not come as

a surprise to the reader, especially since the relationship between hospitals and

universities was positively influenced by medical education reform in both Japan and the

United States, drawing the two closer together, but with negative results in individual

patient care.

Once hospitals married to medical institutions in the US and Japan, other

symptoms of professional strain presented. Patients became a necessary invention for

producing professionals with an artificial sense of professionalism. At one point, the

accredited Tokyo University Hospital only allowed patients entry if the situation of his or

her illness had the capacity to benefit the education of the training doctors.[81] The first

criteria for admission were that the patient condition was essential for academic research

and that the patient submitted an autopsy request form at the time of admission. This so-

called "patients for academic research" system continued until after World War II.[82]

Coincidentally, "it was not until after the Second World War that hospitals began to

provide medical-care facilities for everyone throughout the country."[83] In the United

States, physicians who were increasingly gaining an elitist understanding of their

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[80] Kiyoshi Iwasa, "Hospitals in Japan: History and Present Situation," *Medical Care* 4, no. 4 (1966) : 241.
[81] Sakai, "Inpatient Facilities in Japan," 354.
[82] Sakai, "Inpatient Facilities," 354.
[83] Iwasa, "Hospitals in Japan," 241.

professional status started to dominate[84] in hospital logistics and affect patient flow,

without even being employees or educators of the institutions. American physicians

would admit patients that benefited the hospitals or the physicians practice economically,

rather than referring patients based on a match to the resources required for treating the

patient's illness. The latter as well as the following extend slightly beyond the main

historical focus of this chapter. On the topic of "current" small hospitals and clinics,

according to an observation as late as 1966, "there is no clear distinction between these

two types either in the medical services they provide or their role in the community, and

sometimes they tend to compete for patients rather than cooperate for the benefit of the

patient."[85] Thus, past compromise affects present compromise. Whether extrinsic factors

have compromised professionalism or an intrinsic lack of professionalism has

compromised patient care, currently, "professionalism" plays an equal part on both sides

of the analogy.

At the threshold of modernity, public health and patient care consequences as a

result of the training of medical professionals was very real after reforming medical

practice and medical education. The flux of physicians from rural to urban areas fed the

frontier of the next health century[86] in a way that mimics the clustering occurring at

university hospitals in Japan and the US.[87] Professionals experienced the stress on the

medical systems as they changed and experienced educational, political, and economic

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[84] Shi, "Historical Overview," 55.
[85] Iwasa, "Hospitals in Japan," 245.
[86] Term used by Edward Shorter.
[87] Trends of long inpatient stays (longer in Japan than the US in part for cultural reason) and a lack of general physician care (which is in deficit in the US already) are directly symptomatic of when change occurred in the medical order of things a century earlier. These are the symptoms that have been treated before, so maybe now the chronic illness can be better identified in this encounter with reform? This is a necessary question to ask. (For more context about trends in Japanese inpatient facilities, see Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*).

reform. Today, medical systems are experiencing tedious reforms in insurance policy and managing increasing amounts of government expenditure on healthcare, as the first chapter of this thesis introduced. Furthermore, with medical education changing for the first time since the 1870s, professionals will be set to reexamined standards while in chorus with the cacophony of outside stressors to the medical system. The medical societies in the United States understood the necessity for medical education reform then as much as they acknowledge it today, which is why a study of past repercussions is less than an operative suggestion.

From licensure to training young doctors, developing the professionalism of professional physicians has had its various impacts on the delivery of care to patients. Therefore, as the inadequacies in medical education are beginning to be re-addressed now while the investment is current, combined study of the medical educational system between Japan and the US has potential for restoring altruism in practice.

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Chapter II. Debriefing Professionalism

Now that the reader is acquainted with the historical context involved in developing the medical professionals of biomedicine, as well as the consequences to patient care, a new argument can be proposed. This chapter will investigate the status of the concept of professionalism in the US and Japan, while estimating the awareness professionals have of their own professionalism. If professionals have been used to acquiring professionalism through experience, then medical education should focus more exclusively on whether or not professionalism can be taught, and how it can be accomplished in the training of future physicians.

The previous chapter has already made the case for different beginnings for biomedicine in Japan and the US, and shown that the licensure, which defines medical practice as a professional one, is only as recent as the late 1800s. In doing so, similar trends unfold in the historical narratives. Japan and the US both receive Western medicine extrinsic to their own practices. At modernity's threshold, politics and economy played into the reform of standards. Implementing standards initially reduced the number of qualified institutions and physicians who would become the new frontier of professional medicine, but a gradual increase and ultimate influx of young doctors became the force of health care delivery in the early twentieth century. The increased emphasis on education and the relationship that universities held with hospitals made patients into experimental subjects. Although educators and medical students at this point in the early 1900s were professionals, the conditions in society meant that an unavoidable compromise of professionalism was made at the cost of individual patient care. Meanwhile, several versions of the codes of medical ethics had already been amended.

Consider the codes of ethics in medical practice, which articulate medicine as a profession.[88] The original Medical Code of Ethics adopted in the US in May 1847 outlines the duties of physicians to patients and patients to physicians, duties for the support of professional character, professional services of physicians to each other, in regard to various offices and to consultations, in cases of interference and differences in opinion, and finally the duty of physicians to the public, and the public to physicians.[89] While part of the responsibility bestowed to physicians was the education of the public on quackery,[90] since self-constituted physicians were ever rampant, there was no such mention of professionalism in medical education or among medical students. As for Japan, while the doctor patient relationship was governed by the concept of a parent-child relationship, there was no purview of medical ethics before the Second World War.[91]

Temporally, this makes sense because medical education was not a focus until later in the nineteenth century for both nations, but it does point out that perhaps professionals were not aware of their own professionalism. Furthermore, while the reading of professional duties is encouraged,[92] even now it should be questioned how

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[88] "History of AMA Ethics," *American Medical Association,* 1995-2016. http://www.ama-assn.org/ama/pub/about-ama/our-history/history-ama-ethics.page?.

[89] American Medical Association. *Code of Ethics of the American Medical Association, Adopted May, 1847.* (Philadelphia : Turner Hamilton, Assembly Buildings, 1871). Original from the University of Chicago.

[90] AMA, *Code of Ethics,* 11. One such responsibility addressing patients is the following: "Patients should never allow themselves to be persuaded to take any medicine whatever, that may be recommended to them by the self-constituted doctors and doctresses who are so frequently met with, and who pretend to possess infallible remedies for the cure of every disease. However simple some of their prescriptions may appear to be, it often happens that they are productive of much mischief, and in all cases they are injurious, by contravening on the plan of treatment adopted by the physician."

[91] Rihito Kimura and Laura Bishop. "Contemporary Japan." *Encyclopedia of Bioethics*, revised edition, vol. 3 (1995) : 1496-1505. http://www.bioethics.jp/bios-japanall.html. This does *not* imply that Japanese physicians were not professionals prior to World War II. If, for the purposes of this thesis, a professional is defined by his or her licensure, then a code of ethics operates to articulate his or her responsibilities as a professional.

[92] Sox, "Physician Charter," 243.

well it is taught. Physicians seemed to be hard-pressed between the appropriate education of young doctors and their own responsibilities to individual patients.

Use of the Term "Professionalism" in the US and Japan

Japan adheres to a code of ethics by the World Medical Association, and the United States adheres to a code of ethics by the American Medical Association. The Japan Medical Association also has a separate set of six outlined principles, which articulate medical practice as the responsibility of achieving continued education, integrity, trust of the patient, respect for other medical professionals, respect for the public service of healthcare, and disengaging with medical activity for profit.[93] Turning back to the question that the Physician Charter posed to itself in 2002, does the professionalism as outlined in the document represent the traditions of medicine in culture other than those in the West, where the authors of the charter have practiced medicine?[94] To tune the inquiry to this thesis, what is the Japanese perspective of professionalism as compared to the US? Since both are wealthy nations that practice biomedicine under professional license, these types of comparisons can be made.

Despite the categorization of the term "professionalism" as Western, professional character is clearly articulated in Japanese practice. According to a comprehensive study of professionalism and its discussion in Japan,[95] professionalism has been compared to the manner of *bushido.* Not to imply that *bushido* governs Japanese society as much as it has in the past, or to suggest it is synonymous with professionalism, but it does imply that

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[93] Japan Medical Association, "Principles of Medical Ethics," *Japan Medical Association*, 2016. https://www.med.or.jp/english/about_JMA/principles.html.
[94] Sox, "Physician Charter," 243.
[95] Hiroshi Nishigori, Rebecca Harrison, Jamiu Busari, and Tim Dornan, "Bushido and Medical Professionalism in Japan," *Academic Medicine* 89, no. 4 (2014) : 560.

this influence has been involved in the articulation of the medical profession there.[96] An

assessment of the differences between the Physician Charter and the principles of *bushido*

as influencing medical practice concludes that virtue ethics are at play, and that ethics of

practice in the US are judged as an act of *doing* in Western thought versus *being* in

Japanese thought.[97] There is no equivalent word for professionalism in the Japanese

language. In fact, when posing questions to Japanese physicians about professionalism in

translation for the purposes of this research, the questions were regarded as difficult to

understand,[98] and instead the word *taido*[99] was used in discourse about the subject.

For similar reasons, the Professionalism Committee of the Japanese Society of

Medical Education is one of the governing bodies on this matter. In fact, in 2009, the

Ethics Education Committee was renamed the Ethics and Professionalism Committee.[100]

The use of the word "professionalism" in the article remains not translated, and is written

in foreign phonetic alphabet.[101] In summary, the article presents a new approach to

professionalism in medical education at all levels of medical training, an approach highly

supported by the argument of this thesis. It goes on to introduce the topic by summarizing

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[96] Nishigori, "Bushido." The article lists seven principle virtues of Bushido as rectitude, courage, benevolence, politeness, honesty, honor, and loyalty.

[97] Nishigori, "Bushido," 563. This highlighted difference in virtue ethics that bushido belongs to is an interesting point to make considering that standardized patient practice is a dual role-play involving two actors. Virtue ethics "concerns the character of the actor."

[98] 分かりにくい (*wakari-nikui*): difficult to understand. Response to posed questions about the meaning of "professionalism."

[99] 態度 (*taido*) an attitude; a manner; a behavior. ある物事に対した時の、人のようんです。動作・表情などの外面に表れたふるまい （スーパー大辞林）。

[100] Yasushi Miyata, Hideki Nomura, Seiji Bito, Keiko Koumoto, Mayumi Asahina, Koichiro Itai, Atsushi Asai, Takahiro Amano, Sadayoshi Ohbu, Eiji Goto, "Consensus Statement; integrating professionalism education into undergraduate, postgraduate and continuing medical education, 16th ethics and professionalism committee, Japan Society for Medical Education," *Igaku Kyoiku / Medical Education (Japan)* 42, no. 2 (2011) : 124.

[101] プロフェッショナリズム (*purofesshonarizumu*). This observation alone is reminiscent of the internalization of international medical practice into existing Japanese medical practice.

the many changes that Japan's healthcare is facing, some of which are mentioned in the introduction chapter.

So as professionalism is increasing in discourse among health care professionals in the field, and transnational comparisons of articulated medical service are being made, this suggests that professionals themselves are not explicitly trained on what it means to be professional. Professionalism is not a consistent doctrine, nor should it be, knowing that healthcare is dynamic and so is society. Rather than pure misunderstandings of the professional role, it could also be the case that "assumptions about medical professionalism are changing, as they ought to be."[102]

Professionalism in Unstructured Interview

As part of the research involved in this thesis, several physicians and health care officials were interviewed[103] about the medical system in its current state as well a singular question regarding "professionalism" in order to produce discussion. The responses through unstructured interview were a telling contribution to the understanding of professionalism currently; responses corresponded with the uncertainty of professionalism in practice and its effective delivery in medical education. With Japan and the US both adjusting medical curricula and healthcare goals in recent years, professionalism as a focused topic is not simply a loss of translation, but a recognized medical obligation.

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[102] Robert B. Taylor, *On the Shoulders of Medicine's Giants, What Today's Clinicians Can Learn from Yesterday's Wisdom,* (New York : Springer Science and Business Media, 2015), 3.

[103] Healthcare officials interviewed at Keio University provided context to the Japanese healthcare system and general knowledge of medical school curricula, whereas interviews with physicians at the UNC SOM were specifically asked about professionalism for the purposes of understanding its understanding in US medical training. Some questions were posed to Japanese physicians, but this portion of the research did not follow through. This is a limitation that merits further study.

Uncertainty about the meaning of professionalism is not a conundrum of the past. After asking three physicians at the UNC School of Medicine a variant of the question "what is the meaning of professionalism," the discussions can be summed in three different points. The exact definition of professionalism is not always conveyed in medical education, professionalism is too broadly defined to have a singular definition, and professionalism is a role that fosters trust.

Unstructured Interview: The Powerpoint Slide

After participating in a lecture for first year medical students in the first block of their medical curriculum on physical exams, it was noted that "professionalism" was projected on a presentation slide as a reminder for upcoming Community Week. Community Week is one of two required weeklong clinical rotations for first and second year medical students that occur in the fall and the spring. Specifically, the fall Community Week focuses on the patient interview. When professionalism was mentioned, however, it was not defined; the medical students acknowledged the reminder to act like professionals and nodded. Following up with one of the physicians in the Clinical Skills and Patient Simulation Center on a rotation at the medical school to teach these physical exam skills,[104] it was clear that professionalism was not emphasized at this level of medical education. After further discussion, it was also clear that the question "what is professionalism" could not be finitely answered. This reaped positive results, implying that professionals in the field are aware of the vast amount of meaning and practice behind "professionalism," but it also is indicative that medical students are *not*

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[104] The new curriculum at the UNC SOM requires that first year medical students spend the first block of their study harnessing the skills required of performing a physical exam, without knowledge of studying anatomy. In the next block, students begin studying anatomy in November of their first semester as a medical student.

aware of the vast categories of medical performance that professionalism expands. As a

lasting remark, the physician admitted they would "go back and look up more about the

subject," thereby questioning their own understanding of the topic.[105]

Unstructured Interview: A Book for Reference

Similar to the previous discussion with a medical educator in the standardized

patient labs, a physician working at UNC hospital who regularly trains resident

physicians admitted to the broad span of implications behind the word "professionalism."

In fact, the first interview was postponed for a later date to allow enough time to

introduce and discuss the subject. This physician outlined how professionalism

encompasses everything from appropriate dress to correspondence with patients and other

health providers. Knowing what is appropriate with a patient and what is inappropriate

(and such conflicts exist outside of medicine) is a practice of professionalism. Stemming

from appropriate behavior, the physician explained that when professionals encounter

issues with medical boards, it is not because they "didn't tie a knot tight enough"[106] when

suturing a patient, rather their behavior is the point in question. Remediation of residents

and physicians is ultimately a result of unprofessional behavior, from dress to flirtation[107]

to immaturity. For medical students and residents, most of which are highly successful

individuals, issues with professional behavior are a result of "attitudinalism."[108] After

being praised for the entirety of their academic career and being successful throughout,

the accomplished view they might have of themselves is an illusion of professionalism.

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[105] Mike Gilchrist (Clinical Skills Center) in discussion with the author, October 2015.
[106] Amelia Drake (Craniofacial Clinic) in discussion with the author, March 2016.
[107] According to the CSPSC Director of Assessment, sometimes this issue arises in standardized patient encounters, along with medical students not suspending disbelief during the encounter. Here, the importance that standardized patient encounters have in implementing professional behavior is emphasized.
[108] Drake, 2016.

One of the final remarks in this interview parallels a common thread in this thesis; although claiming not to be a voice of authority on "professionalism," the physician believes that "professionals are not aware of their own professionalism." Acknowledging that this unstructured interview would not be comprehensive enough to define professionalism, the physician provided *Medical Professionalism, Best Practices,* a publication by the Alpha Omega Alpha Honor Medical Society, for further reference on the topic.

Unstructured Interview: Standardized Patient Practice

Attending a lecture on counseling in psychiatric clerkships for third year medical students,[109] it was noted that the physician leading the discussion valued a sense of virtue ethics in the role of being a counselor as a physician. Rather than performing the actions of a counselor, the most professional aspect of the practice was to acquire the trust of the patient by being a counselor. This physician emphasized the establishment of rapport with a client or patient seeking medical counseling. The focus of the standardized patient encounters following this lecture in particular was not on the very obvious, chronic medical conditions or immediate life style changes that the patient is already aware of, but rather the underlying relationship that physicians should develop with the patient.[110] In fact, it is quite parallel to one charge outlined in the original Medical Code of Ethics.

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[109] Of particular interest is the context behind this clerkship for the third year medical students. This is arguably the first counseling session with a standardized patient that is not resolved by the end of the encounter. These practice sessions have occurred before, during and after the clerkship in order to give students experience in counseling, and area the curriculum is currently strengthening.

[110] Erin Malloy, "Counseling in Psychiatry" (lecture at the UNC School of Medicine, Chapel Hill, NC, February-March 2016).

> There is no profession, from the members of which greater purity of character, and a higher standard of moral excellence are required, than the medical; and to attain such eminence, is a duty every physician owes alike to his profession and to his patients. It is due to the latter, as without it he cannot command their respect and confidence, and to both, because no scientific attainments can compensate for the want of correct moral principles.[111]

Part of being professional, as defined by this discussion, aside from suspending disbelief in the standardized patient encounter, is to suspend factual scientific attainment when a patient is in need of respect and confidence in his or her provider.

Teaching Professionalism in New Curricula

An article in the AMA Journal of ethics questions whether or not professionalism can be taught, and in doing so, is quite articulate in its explanation of the current state of professionalism in medical education, and among professionals for that matter.

> Before any attempt to answer the question "Can you teach professionalism?" I think *professionalism* requires some form of definition. It is striking how many papers and essays deal with aspects of this question without any real definition of the term. Professionalism is more easily appreciated than defined.[112]

Between the lines of scientific literature there is a call to arms that is proposing a reassessment of professionalism. All of these findings point to the fact that professionals, indeed, are not aware of their own professionalism. This complexity underlies almost all discussion on other complex health issues, where the newest of these is the training of future physicians.

After these interviews and discussions with other health professionals, important points about the breadth of the definition of professionalism, the behavior of the professional and the role of physicians as trusted individuals can help to shape

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[111] AMA, *Code of Ethics,* 14.

[112] Jeffrey T. Kullgren and Jerome Lowenstein. "Can You Teach Professionalism? …and If You Can, How?" *Virtual Mentor* 5, no. 12 (December 2003) in the AMA Journal of Ethics.

suggestions for addressing medical professionalism in the training of future physicians. It highlights that either professionalism is burdened by too many variations of meaning, or that there might not be any specific definition given to the term. Moreover, trained professionals in the field are not aware of their own professionalism. The results of this research cannot be any more pressing, considering that the training of future physicians is already happening. Arguing that professionalism *can* be taught in the training of future physicians specifically, the remarks in the unstructured interviews provide a glance at how to approach professionalism as an academic subject at all levels of medical education.

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Chapter III. Prognosis

In November 2015, the UNC School of Medicine joined with the American

Medical Association to create a medical school of the future,[113] and in 2014, Keio

University was selected for the Top Type Category in the Top Global University Project

for committed contribution to global society as a leader of education, research and

medicine in Japan.[114] Accordingly, Keio University in Tokyo, Japan and the School of

Medicine at the University of North Carolina, Chapel Hill in the United States have the

capacity to address professionalism in medical education and clinical practice, nationally

and globally. After a brief outline of the medical curriculum at UNC and at Keio,

this chapter will propose four ways that these universities can independently and

synergistically improve the medical training of their future physicians by integrating one

another's curricula. Based on the conclusions made in previous chapters, addressing the

attitudes of young student doctors, and implementing the teaching of medical

professionalism at all levels of medical education will bring awareness to professionalism

as a necessary element of the healthcare system.

Curricula Outline

The course of medical education from initial years of study to clinical clerkship

and residency is different for Japan and the US. From the perspective of an even earlier

stage, so is the concept of high school education. An academic year in the US begins

roughly at the end of August and ends in June, whereas the academic year in Japan

begins in April and ends in March. High school students in Japan are eligible to enter into

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[113] Jamie Williams, "UNC School of Medicine Joins with AMA to Create Medical School of the Future," *UNC Healthcare and UNC School of Medicine*, November 2015.
http://news.unchealthcare.org/news/2015/november/unc-school-of-medicine-joins-with-ama-to-create-medical-school-of-the-future.
[114] Keio University. "Top Global University Project, Keio Global Initiatives," Keio University, 2014.

undergraduate medical school education, which lasts six years. Once graduated in the US, high school students must be accepted into an undergraduate four-year college to complete prerequisite medical courses. Passing the Medical College Admission Test (MCAT), accepted application requirements and interviews allow entry into medical school, another four years of education.[115] Postgraduate education after medical school in both the US and Japan is a necessary part of extended training and the foundation for working as a medical doctor in the field. This was not always the case, but in 2004 the Ministry of Health, Welfare and Labor in Japan made it law that a two-year residency program was required for graduated medical students.[116] Residency in the US is in most cases at least three years of postgraduate education. At various intervals throughout medical education, appropriate examinations and clinical assessments are administered.

As an overview of the goals for medical students, the Translational Education at Carolina (TEC) curriculum focuses on leadership skills, professionalism, ethics, humanism and service to others. At Keio, areas of expected competency by the end of medical education are medical professionalism, medical knowledge, patient care, communication, contribution to medical care and public welfare, commitment to scientific inquiry, and participation in the global medical community. Most importantly, Keio's unique program highlights professionalism training, research-focused programs and a number of international opportunities.[117] Professionalism exposure begins with first year medical students at both UNC and Keio, but as Table 1 shows, this means that

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[115] In August 2014, the UNC School of Medicine implemented a block program as a new curriculum, Translational Education at Carolina (TEC).

[116] Tadahiko Kozu, "Medical Education in Japan," *Academic Medicine* 81, no.12 (2006) : 1072.

[117] "Overview, Introduction to the School of Medicine," *Keio University School of Medicine*, Accessed October 2015. http://www.med.keio.ac.jp/en/about/overview.html.

medical students at Keio are exposed to professional development four years earlier than

students at UNC. This will be discussed in more depth later on in the chapter.

Table 1. Compared Curricula Outline

Stages	United States – UNC Chapel Hill		Japan – Keio University, Tokyo
1	Undergraduate Education (4 yrs) Basic prerequisite course focus: Introduction Biology with lab		First year medical Early Exposure Program (EEP) Chemistry, mathematics, physics Lab study, foreign language
2	General Chemistry I and II with lab Organic Chemistry I and II with lab Analytical Methods Chemistry Physics I and II with lab		Second Year medical Body focus: histology, anatomy, embryology, physiology, biochemistry
3	Biochemistry Anatomy and Physiology with lab Suggested courses: Psychology, sociology, statistics, genetics		Third Year medical Disease focus: immunology, molecular biology, social medical science. Surgery and internal medicine lectures begin
4	Exam: Medical College Admission Test, Interviews		Fourth Year medical Preparation for clinical rotation Laboratory and Field Studies OSCE, CBT and Final Exam
5	Foundation Phase (MS1+MS2)[118] (12 months, 18 total)	Indivd. Phase	Fifth Year medical Extracurricular Activity Clinical Rotations
6	Foundation Phase (6 months)	Application Phase[119] (MS3)	Sixth Year Medical Clinical Rotations
7	Application Phase (12 months total)	Individualization[120] Phase (MS4)	Professional Rotation[121] Graduate medical education
8	Individualization Phase (14 months total)		
9	Begin Residency Postgraduate medical education		Begin professional career and research[122]

Information presented here from discussion with Jun Mochizuki[123] at Keio University's Shinanomachi Campus and interviews/lectures by Julie Byerley.[124]

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[118] Foundation Phase (18 months total): Combines first and second years of medical education. Basic science of normal function and abnormal function. Three types of courses: medical sciences (organ system blocks), patient-centered care, professional development.

[119] Application Phase (12 months into trimesters): Clinical clerkships that focus on population, services and location. Begins four months earlier than typical third year medical education.

[120] Individualization Phase (14 months): two-month early start for fourth year medical education. Gives students flexibility to choose electives before starting on the residency application timeline.

[121] 初期研修 (shokikenshuu): Two-year professional rotation after graduation from the medical university. This rotation is usually different from the previous institution they studied at. After this two-year rotation, medical graduates finally become a professional doctor who can legally practice as an individual.

[122] 専修委 (senshuui): Professional doctor. This is the general status of a doctor three years after graduation.

Suggestions for Curricula at Keio University and UNC School of Medicine

In this final discussion about professionalism as it is understood in health care and taught in medical education, four suggestions for improving how professionalism is taught will be introduced. Based on the merits of unique curricula at frontier universities Keio and UNC, as well as the conclusions of the unstructured interview responses, professionalism can be better approached through the following: assessing and correcting the attitudes of young doctors and students, thus earlier exposure to professional development skills, increasing use of student involvement in medical education, and integrating more standardized patient practice.

Attitudinal Mismatch

There seems to be a discrepancy in the required education of prospective medical students and the preparation that they receive. More specifically, a variable of maturity is either present or lacking in medical students as they enter into the commitment of this study. As with all other arguments in this thesis, these types of discrepancies and conundrums are not exclusive to current day, but have existed since the beginning of the profession and the development of medical education.

Even when the American Medical Association amended the living Medical Code of Ethics in 1905, this action still did not parallel the types of behaviors observed of medical students. In general, medical students were unprepared for the commitment of medical education and the responsibilities entitled to physicians. Martin Kaufman summarizes an introductory lecture by Daniel Drake in 1847, the same year the American

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[123] Jun Mochizuki (International Coordinator, Medical School Student Office) in discussion with the author, July 2015.
[124] Julie Byerley, interview by Cristy Page, *Training the Physicians of the 21*st* Century.* Your Health Radio. https://yourhealthradio.org/2016/02/05/training-the-physicians-of-the-21st-century-with-dr-julie-byerley/. February 5, 2016.

Medical Association was created *and* in May of that same year when the *first* code of ethics was adopted, that addresses young medical students and their moral character upon entering the profession. Kauffman explains that students "left the influence of their parents [and] the pursuit of knowledge was often cast into the background by the excitements, amusements, and entertainments of the city."[125] The original pamphlet by Daniel Drake on November 1st, 1847, delivers the following introduction.

> The primary object of this lecture, is to aid you in the improvement which may be derived, from studying these excellencies and imperfections of mental character and deportment, by directing your attention to faults and infirmities, which may be fairly assumed to exist among you, the correction of which is not more indispensable to success in the acquisition of elementary knowledge… but as some of you are young, and have just commenced the study of medicine, others farther advanced, and destined to be candidates for graduation at the end of the session: …for the first step towards placing our feet on the right path, is to discover that we are in the wrong.[126]

Robert Taylor rivals this passage in 2015, clearly articulating to young training doctors the gravity of what it means to start on the path of a professional.

> My point to be made, especially to young physicians, is this: The prerogatives described… are yours because of the accomplishments of generations of wise physicians that have preceded you- the giants upon whose shoulders you stand. You have, so far, done little or nothing to justify the lofty position you now hold in society. Thus part of your job description, and one of your long-term career challenges, must be to leave the profession of medicine even more respected, more honorable, than you found it.
> This means that along with striving for excellence in medicine, you must lead lives that inspire confidence in your opinions and recommendations. When you tell a patient that a diagnosis is appendicitis, that surgery is needed, and that you will do the operation, that patient needs to believe in *you.*
> What does this mean for new physicians? It means the end of youthful escapades; no more acting like college girls and boys. You are a physician. People trust you with their health and sometimes their lives. Be the physician your patient needs you to be. Act in ways that justify the privilege and power you are accorded…[127]

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[125] Kaufman, "American Medical Education," 47.

[126] Daniel Drake, *Strictures on some of the Defects and Infirmities of Intellectual and Moral Character, in Students of Medicine: an Introductory Lecture,* University of Louisville : Published by the Class, November 1, 1847, 3-4.

[127] Taylor, *On the Shoulders of Medicine's Giants,* 13.

Taylor supplements Drake in his comments on the moral character of young

physicians in his address by highlighting the reality that many medical students enter

medical training at a young age. For students in Japan, this is right after high school, and

for students in the US, in most cases after four years at an undergraduate college. Without

professional development until this point, there is no exposure to the term, aside from any

definition given to it by an educator or textbook. Prerequisite medical education does not

focus on clinical skills, on maturity or professionalism. Such education exclusively

focuses on the attainment of sciences, but as shown earlier, "no scientific attainments can

compensate for the want of correct moral principles."[128]

There are other reasons that occur later on in the course of medical education

which indicate the need to implement earlier exposure to professionalism, or at least a

remediation of behavior. As was discussed in one of the aforementioned interviews,

residents and other medical students who are accustomed to a successful academic career

attribute unhindered accomplishment to professional status. Unfortunately, this begins to

transcend the undefined boundary between a misunderstood sense of professionalism and

elitism. The use of the term elitism refers to an attitude or behavior of an individual in a

group who regards his or herself as a dominating element of the system.[129] Elitism in

place of professionalism has the extreme potential to injure the teamwork of inter-

professional teams who care for patients with extraordinary cases by compromising

communication, prognosis, and referrals.[130] Again, remediation of residents and

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[128] AMA, *Code of Medical Ethics,* 14.

[129] This definition so acutely given to the term "elitism" is not meant to make professionalism seem completely abstracted. For the sake of the argument, however, it is more profitable to consider the broad definition suggested by one key term rather than by two key terms.

[130] One example of an inter-professional team would be Craniofacial teams across the United States. These teams are one of the only few existing types of practices that exist since managed care in the 1990s hindered the ability for physicians to work in teams and also earn appropriate pay. A Craniofacial team

physicians is often the result of behavior and attitude, not a technical detail. In America at the start of the twentieth century, elitism definitely played a part in the dominating role of physicians who controlled patient flow for economic gain and separatist status from other occupations at the time. By applying what is known today about the compromise to professional practice as a result of elitism then, it is obvious how individual patient care and communication was harmed in the early twentieth century. Therefore, if the attitudes of young training doctors are addressed and exposure to professionalism development achieved, compromises to the practice can be better avoided.

Professional Development at the Beginning of Medical Education

Previous discussion about attitudinal remediation clearly illustrates that many medical students and prospective students are not prepared to enter the course of medical education. While in the past this was definitely an issue of qualification standards and inferior academic achievement, the case now is more one of maturity and professional skill. In order to overcome the deficit of maturity and at least organize the goals of the profession, medicine would profit from earlier introduction to professionalism through coursework at medical institutions. For America, students would benefit from professionalism coursework at the start of their undergraduate career.[131]

First year medical students at Keio University take basic science courses in chemistry, mathematics, and physics which is parallel to first year undergraduate students in American colleges. Because students enter medical school in Japan straight out of high school, however, they are considered medical students at this time. That is to say,

consists of otolaryngologists, dentists, orthodontists, speech-language pathologists, psychologists, and nurses in order to appropriately address the needs of unordinary patients.

[131] Even before students in America are certain of attending medical school, earlier exposure to professionalism could possibly help these students to better realize *what* to expect from their medical education, and thus help them to make more critical decisions about their career.

although first year medical students at both UNC and Keio are introduced to professionalism coursework in their first year, this happens four years later at UNC than it does at Keio.[132] Students in America do not attend medical institutions immediately after high school; four years of undergraduate study is required.

A first year of medical school at Keio University already covers medical professionalism, which is listed in its overview of expected areas of competency. Keio's Early Exposure Program (EEP) gives first year students the opportunity to visit various health care facilities and experience actual health care settings. The objective of the EEP is to allow students to experience challenges that medical doctors and staff encounter when treating patients. Most importantly, it allows first year medical students to develop a mindset for professional development at an early stage of their education. Keio University's School of Medicine was the first university in Japan to use a program with such an approach to coursework in 2014.[133]

Medical professionalism coursework at Keio also spans other course sets with various subjects related to professionalism, including a separate Inter-Professional Education Program (IPE). Established in 2011, this program fosters the application of competence in professional skills with other professionals in healthcare. Specifically, it "aims to improve cooperation and communication between students in the School of Medicine, Faculty of Nursing and Medical Care, and the Faculty of Pharmacy, so they will develop into health care professionals who utilize a group approach to patient-centered care."[134]

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[132] *Refer to the comparison of stages in medical education outlined in Table 1 of this chapter.*
[133] Keio University School of Medicine, "Professionalism," *Keio University School of Medicine.* http://www.med.keio.ac.jp/en/about/professionalism.html.
[134] ibid.

Group approach to patient-centered care is a resurfacing ideal since its phasing out in the early 1990s as a result of managed care. At UNC, the TEC curriculum has increased the flexibility of medical education for its students. The individualization phase, which appears at the end of the first year and finishes at the fourth year of education, allows students to focus on their specific research interests and electives to assist them in becoming the type of professional that they envision for themselves. As a result of this, according to Julie Byerley, Vice Dean for Education at the UNC School of Medicine, the new curriculum has encouraged faculty members throughout the school of medicine and other university departments to work together in ways that they had not before. Even so, first year medical students and fourth year medical students at UNC have blocks of professionalism coursework just like first year medical students at Keio. These are similar to Keio's EEP and IPE Programs, but the argument can be made that earlier exposure to professionalism should be made in American education even before medical school.

After high school, most students in America seek to enter an undergraduate university for further education. At this level, those who aspire to enter medical school are required to take a regiment of strict science courses to prepare for the Medical College Admission Test, which is a piece of the application to medical school. On the contrary, there are no such preparations, or necessarily needs for, clinical practice or professional development. UNC is not entirely lacking in this area, however. A pioneered course three years ago in 2013 entitled Introduction to Clinical Medicine for Undergraduates allowed undergraduate students, at least sophomores, interested in medical school to work an internship as coursework for a year at the school of medicine.

This internship included working as a warm body for medical students learning physical exam skills lead by a medical educator, as well as attending lectures tailored to undergraduates about the health care system in America. From this, some students are able to continue working with medical students by becoming a standardized patient in the Clinical Skills and Patient Simulation Center in UNC's medical education department.

In summary, access to professionalism coursework at early stages of medical education, but also undergraduate education has the capacity to strengthen the mindsets of young training doctors. Furthermore, flexibility in curricula gives medical students the ability to discover other interests in healthcare while working with medical and university staff in inter-professional ways before entering the field of healthcare.

Student Involvement in Medical Education

Given UNC's goal for a more flexible and modern medical curriculum as the initiator of TEC in August 2014, students are able to become more involved in their medical education. TEC has also fostered new collaborations among university faculty in reaching the needs of medical students pursuing electives in healthcare coursework. It seems that TEC has benefitted students in helping them to become more involved in their education, and also in understanding the dynamics of inter-professional teams with first hand experience.

As for Japan, the case for involvement in medical education is not necessarily within the same vein. According to an article in *The Clinical Teacher* about medical students and curriculum development, there were three main reasons that students decided to participate in their medical education: extracurricular interaction with faculty members, engagement with highly motivated peers, and student values for serving the

public.[135] Focusing on the first of the three points, there appears to be a more rigid order of professional behavior when considering the educator-student relationship in ways not expressed in American medical education.[136] It is not a magnificent hurdle for medical students in the United States, in most cases, to be able to speak freely with medical professors. One student cited in the article mentions the enjoyment of talking with teachers in their working group, since "there aren't that many opportunities to talk to professors." Another comments on the realization that teachers "devote more thought to [their] education than [they had] initially realized," implying that "some of the errors in communication between students and teachers may be based on erroneous assumptions."[137] For schools that are as tightly knit among alumni and students as Keio, and for universities with unique, flexible curriculums that actively engage students to think deeply about their education, it appears that one benefit is an introduction to inter-professional communication, not exclusively the sheer involvement of contributing to the curriculum. If student involvement in medical education is able to foster real-life situations where inter-professional training and exposure is abundant, then a new layer of professional development can be included in medical education when students become more involved.

Another aspect of student involvement is peer evaluation, which also has had impacts on the development of student professionalism skills in medical education. A comprehensive article about assessing professionalism in early medical education via peer evaluation and self-evaluation shows that students are able to "gain insight into their

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[135] Hiroshi Fujikawa, Jeffery Wong, Hiroki Kurihara, Kiyoshi Kitamura, and Hiroshi Nishigori, "Why do students participate in medical education?" *The Clinical Teacher* 12, (2015) : 48.
[136] The relationship between educators and medical students in Japan merits further study.
[137] ibid.

own performance,"[138] which in itself is the highlight of the conundrum of medical professionalism as portrayed by this thesis. In order to become clinically competent in medical professionalism, a very obvious first step in conjunction with early exposure to professionalism coursework would be the establishment of more self-evaluation and peer evaluation activities that give immediate feedback to medical students. This could be the caveat of professionalism development in medical education that overrides the trend of professionals being unaware of their own professionalism.

Standardized Patient Practice

One area of medical student course study that provides feedback to the students is objective structured clinical examination (OSCE). This type of encounter is implemented already in Japan and the US's medical schools to a certain degree, although there is more use of standardized patient practice in the US. Standardized patient practice requires a medical student to suspend disbelief in an encounter with a patient who is acting out a case history or condition about which the medical student is being assessed for competency. In essence, both the patient and the medical student put on roles in order to create an authentic, professional encounter. In the case of UNC's medical school education, the Clinical Skills and Patient Simulation Center uses various standardized patient cases at different intervals of the TEC curriculum. OSCE clerkships in family medicine, OB/GYN, psychiatry, surgery and pharmacy all cultivate essential clinical skills, thereby cultivating professionalism.

If standardized patient practice could focus more intently on the feedback given to medical students about the encounter, this would alleviate future burdens in clinical

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[138] RE Bryan, AJ Krych, SW Carmichael, TR Viggiano, W Pawlina, "Assessing Professionalism in Early Medical Education: Experience with Peer Evaluation and Self-Evaluation in the Gross Anatomy Course," *Annals Academy of Medicine* 34, no. 8 (2005) : 487.

rotations at hospitals as well as engender a sense of personal assessment when it comes to professional behavior. After a standardized patient encounter, standardized patients must consistently and accurately report back the performance of the medical student since evaluators are not present in the room during the testing encounter.[139] This is done on a computer with various categories of questions. One such category is a Professionalism Assessment, with the option to mark "yes" or "no" for the following three questions after a surgery OSCE: communicates effectively, addresses patient's anxieties, is truthful when asked about his prior experience. In some cases, the latter question is often a "no."

As for Keio and other medical universities in Japan, the increased use of standardized patient practice would not only contribute to self-assessment and professionalism development, but also increase student involvement in their education with their attending faculty members. The Keio Journal of Medicine admits that one area of undergraduate medical education for reform would be "creating more physical exam practice sessions including both real and standardized patient experiences."[140]

It seems to be the case that there are few places in literature where comments are made about the benefits that medical students gain when working with patients in teaching hospitals or in clinical clerkships. Historically, there is little to no evidence of the affect that attending teaching hospitals for rotations had on medical student education, or individual patient health for that matter, in the early twentieth century. Potentially, this could have aided in their professional development, although it is known that their increase in number in the early 1900s definitely led to an unavoidable consequence in

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[139] In most cases, the encounter is either being filmed, as with the UNC CSPSC, or a one-way mirror governs the observation.

[140] Alan R. Teo, "Misperceptions of medical education in Japan: How reform is changing the landscape," *Keio Journal of Medicine* 56, no. 2 (2007) : 62.

patient care overall. In fact, the much-cited Mark Kaufman spends most of his time in *American Medical Education* sifting through the various accounts of licensure and policy developments that helped to create professionals in the United States. According to one book review, his work "pays no attention to what medical students learned in the classroom, clinic, or laboratory… scarcely [mentioning] the revolution in medical education that… allowed them to diagnose real patients, assist with actual deliveries, and aid in surgical operations."[141] This type of professional behavior needs to be the focus of medical education, not just the focus of literature on the subject. How to give medical students the best possible encounters with professional development can most certainly be accomplished by simulating encounters with patients before medical students even reach clinical rotations in a hospital setting. Furthermore, standardized patient practice requires maturity, suspended disbelief, self-assessment, evaluation and interaction with patients as well as other providers who grade the encounter. To implement more of these goals in medical education would increase the efficacy of professionalism education at all levels.

Checking All That Apply

As the health care world becomes more aware of its own deficits and complexities in practice, there will be more cause for reform in its various sectors. One of which is medical education, and reforming this area of health care is not a new concept, although many would agree that medical education has remained stagnant for over a century. With more technological advances in medical practice to alleviate the burdens of physicians and students alike, this new opening can be occupied by the needed focus on patient care.

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[141] Ronald L. Numbers, "Martin Kaufman: American Medical Education: The Formative Years, 1795-1910 (Book Review)," *Isis* 70, no. 3 (1979) : 472.

Students and physicians no longer have to course through vast amounts of scientific attainment in order to care for a patient at this day in age. Since technology and other advancements have alleviated this burden, there is more opportunity to focus on medical education, on medical professionalism, and the relationship between the two.

Society is also a very global one, today. One hundred years ago, global medical curricula were not being studied in tandem in order to synergistically improve healthcare, but today they can be. Medical institutions with the capacity to evaluate their own performance and enhance the performance of others, such as Keio University and UNC, should be considered for further study on the topic. Institutions such as these already have professionals who are willing to assess their own occupations and the professionalism that underlies the complexities that physicians face everyday.

By checking all the ways in which medical professionalism applies here, if UNC and Keio can focus on the attitude and behavior of medical students in order to adjust professionalism coursework at earlier stages of education, so can other medical institutions. Furthermore, increasing the exposure to medical professionalism will engender professionalism development skills, which can be best applied through reflexive evaluation of self and peers in activities like OSCE's that are already integral parts of coursework. If all of these boxes can be checked in medical education, professionals can become more aware of their own professionalism in inter-professional relationships, in the medical classroom, in literature, and in healthcare overall. In all of the history of medicine, today can be the onset of focused study on professionalism as a well-defined and practiced concept.

UNC School of Medicine faculty and students came together to create a new curriculum, even though the original was already functional. The reasoning behind changing the curriculum was that the curriculum should be more modern.[142] Keio University harnessed its strengths as a leading university in Japan to reach out globally for a new modern approach to research and medicine. These are not the first universities to do so. As this thesis introduced, "there is probably not a medical school in the country," in the world, "which has not made drastic alterations in its curriculum to meet the needs of a changing [society] and enormously expanding body of scientific knowledge."[143] Countless times, however, such incremental changes were not successful. Many professionals count past reforms as failures, or in other cases not efficacious. In all of these attempts, the profession itself is the foundation of the complexities of the issue. Training professionals to understand and evaluate their own professionalism will be the next reform necessary within healthcare.

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[142] Byerley, *Training the Physicians of the 21st Century.*
[143] John H. Knowles, *The Teaching Hospital, Evolution and Contemporary Issues,* (Cambridge : Harvard University Press, 1966), 66.

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The Same Symptoms Present Elsewhere: Conclusion

A team of professionals meets to discuss a patient with a chronic illness. One professional is a certified pathologist, the other a medical doctor, and each brings up the same concern about the patient. The pathologist insists on therapy, but the medical doctor is already preparing for surgery. After the rest of the team makes suggestions for the patient's care, it is decided they will see the patient back in one week for a pre-op visit. The pathologist remains unheard for the rest of the discussion.

One responsibility given to medical physicians is the charge to continue in education. As society grows and changes, and populations fluctuate, so must healthcare undergo reform and physicians reeducate accordingly. Among these efforts are the realizations that professionalism as a topic in healthcare remains largely without definition, even when it is used in the classroom. Given that educators and professionals in healthcare have not been aware of their own professionalism, and that problems are not problems until the consequences are noticed, what has lead professionals to begin questioning and evaluating their own understanding of professionalism? What consequences are now becoming most obvious?

As easy as it might be to displace blame in healthcare on the more vast issues of insurance policies, government spending or resource availability, it is not suboptimal to consider physicians' lack of professionalism with their patients as the root of malpractice and other complexities. After a comprehensive look at literature on the topic of malpractice, there seems to be an overwhelming amount of evidence to support the argument that a breakdown in the patient-physician relationship with its own side effects is a prevalent trend. With communication as a central place for concern, patients in one

study explain how "physicians would not listen, would not talk openly, attempted to mislead them… devalued patient or family views, delivered information poorly, or failed to understand the patient's perspective."[144] After reading through this thesis and having a basic understanding of the responsibilities outlined in the medical code of ethics, the reader should notice that all of the compromises listed above are compromises to professional behavior.

Compromise to professional behavior thereby has an effect on the compromise of inter-professional behavior. Some of the most common obstructions to teamwork in settings where professionals work together on the behalf of an ill patient include poor communication, conflicting power relationships, ideological differences, and role confusions.[145] In the case of the ill patient, there have been countless instances where unnecessary examinations, reexaminations, or surgeries have been conducted where better communication and appreciation of roles between professionals could have prevented such consequence. Again, these types of conflicts should be familiar to the reader from a historical and a current perspective, especially when considering the content discussed in chapter two of this thesis. Inter-professional goals also exist outside of medical training, outside of healthcare, in other professions. In these cases of malpractice where compromises in professionalism have occurred, the next best practice is remediation. Remediation of physicians occurs when physicians, residents, or students have abandoned their obligations and responsibilities to the profession and have lapsed in its practice.

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[144] Beth Huntington and Nettie Kuhn, "Communication gaffes; a root cause of malpractice claims," *BUMC Proceedings* 16 (2003) : 157.
[145] Rawson, Don. "Models of inter-professional work, Likely theories and possibilities," in *Going Interprofessional 2001,* ed. Audrey Leathard, (Britain : Routledge Press, 2001), 39.

Much like medical education and professionals in healthcare are undergoing remediation for lapses in professionalism and the training of future physicians, professionalism itself is undergoing remediation in professional discussion. When the compromises to patient care become more obvious, and what has been blamed for malpractice and complexity in the past is removed, underlying foundations can be examined. In the case of the chronically unidentified illness of the patient, the underlying complexity to the insurance he or she pays, the government he or she belongs to, and treatment he or she is prescribed are all framed by the medical physician's appropriate adherence to professionalism. The diagnosis for the complexity of the healthcare system, like the complexity of the illness that remains chronically unidentified, is the lack of awareness among professionals over their own professionalism. This is precisely why medical education needs to focus on the way in which professionalism is approached.

Even though medical education curricula are currently in a state of change, if professionals who do not recognize their own professional behaviors continue to educate the future physicians of Japan and the US without making changes to this concept specifically, then medical educators will perpetuate one of the largest complexities of the biomedical healthcare system as it currently exists. The conundrum of medical professionalism cannot be perpetuated. Medical education should implement changes to medical professionalism awareness at a time when curriculums are in a process of change. Medical universities should make an effort to assess the attitudes of young doctors and medical students, expose students to professional development skills earlier on, increase the use of student involvement and self-evaluation, and integrate more standardized patient practice.

Further research for this topic is a necessary investment for healthcare, and a necessity for the further development of inter-professional teams that have overwhelming potential to contribute to well-delivered, patient-centered care. Amending the teaching of medical professionalism in the classroom will amend the inter-professional relationships of future physicians, and make existing healthcare professionals more empowered to deliver the best possible patient care. In its resolve, this thesis leaves the reader with the following passage for further contemplation and further study on the subject, as well as an awareness of the complexity of professionalism as one of the most subjective standards in biomedicine today.

> I suggest three ways I think we should be broadening the discussion for us as educators and leaders. First, the professionalism discussions should be about how we raise the consciousness and behavior of students and trainees (not just those who need remediation). Second, we need to think about professionalism in the context of the organizations in which we all function and how these organizations can have positive or negative influences on professional behavior. And third, we should be thinking about an inter-professional professionalism that involves the other health professions that are our partners in caring and teaching.[146]

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[146] Richard L. Byyny, Maxine A. Papadakis, Douglas S. Paauw, *Medical Professionalism, Best Practices*, (Menlo Park, CA : Alpha Omega Alpha Honor Medical Society, 2015), 137.

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